Palliser PCN

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

Annual Report

Sections 1 and 2

For the period: April 1, 2025 to March 31, 2026

To be submitted to PPHS **no later than June 30, 2026.**

1. Period Overview

1.1. Summary

The Palliser PCN is in its 20th year of operation and sees maximization in the number of participating physicians, the number of clinics, the number of in-clinic PCN professional staff and the number of patient enrollees.

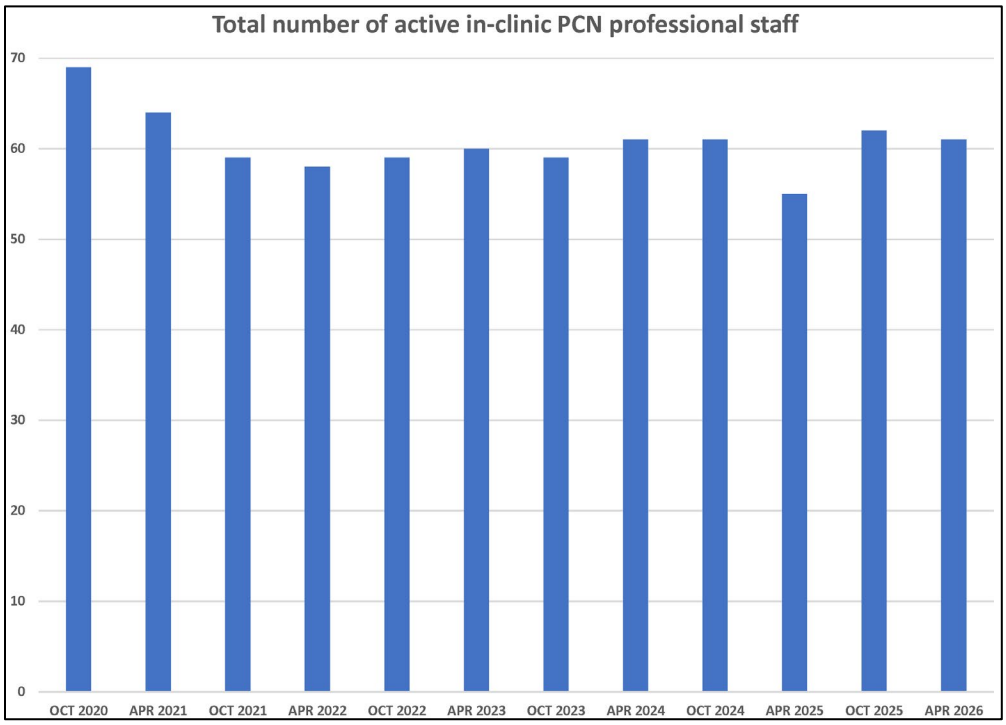


Figure 1 - Active in-clinic PCN professional staff, 2020-2026

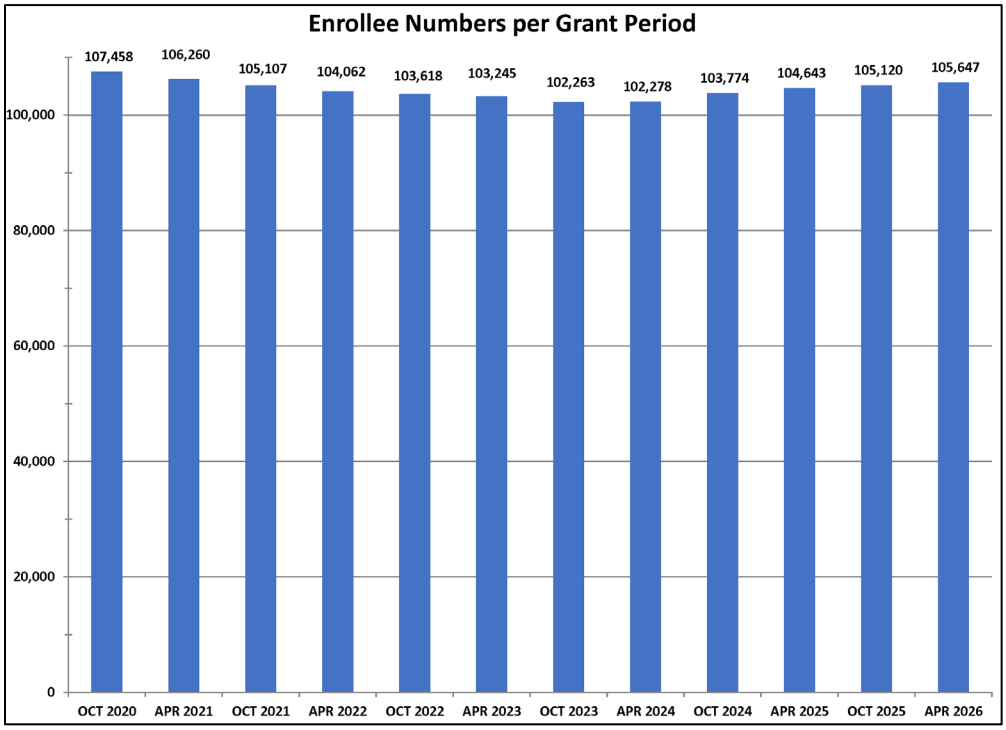


Figure 2 – PCN Enrollee numbers per grant period, 2020-2026

The PCN continues to seek that current and future activities align with at least one of the four PCN Provincial Objectives. This approach ensures the PCN is a responsible steward of public funds and operates with a foundation of service excellence.

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

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

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

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

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

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

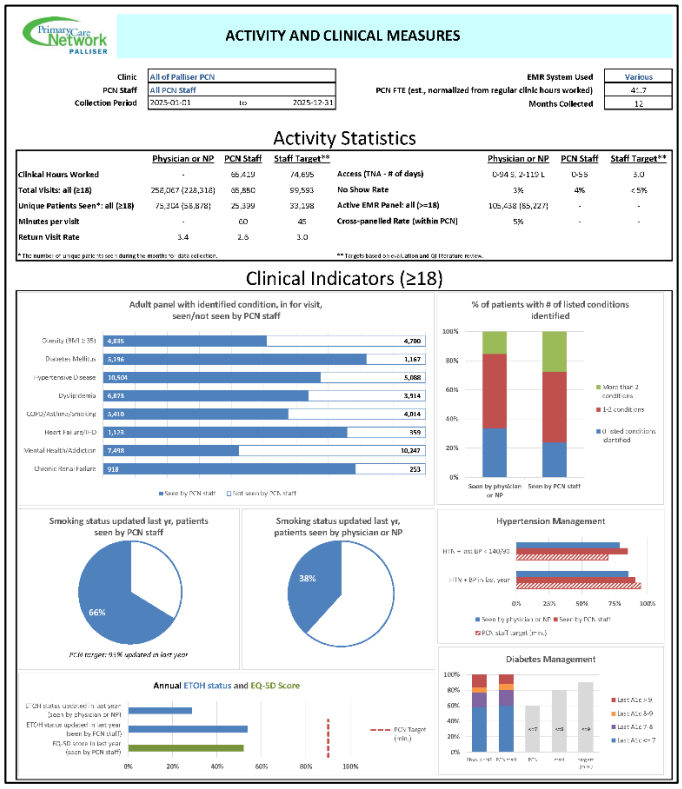
Provincial PCN Strategic Directions	Provincial PCN Priorities	Palliser PCN Enablers	Palliser PCN Priority Initiative Applicability	Palliser PCN Activities	Palliser PCN Short-term Outcomes	Palliser PCN Medium-term Outcomes	Provincial PCN Long-term Outcomes
A. Bring about cultural change	Accountable &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

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

[1] Palliser Primary Care Network. (2026). 2026 Employee Handbook.
[2] Hamza, D. M., & Regehr, G. (2021). Eco-normalization: Evaluating the longevity of an innovation in context. Academic Medicine, 96(11S). https://doi.org/10.1097/acm.0000000000004318

This model aligns with the provincial context, being bookended by the provincially-identified Strategic Directions[3] and four PCN Objectives on the left and the long-term Provincial Outcomes on the right. Palliser PCN's internal activities and evaluation objectives are defined within this framework and focus predominantly on progress toward achievement of its short-term and medium-term outcomes.

With remote access to 100% of health home EMRs, the PCN's use of its Activity and Clinical Measures Sheet supports focused clinical quality improvement prioritization and evaluation. With a primary focus on *measurement for improvement*, as opposed to that of accountability or research[4], clinical data is extracted from health home EMRs and presented in various forms – most regularly, an Activity and Clinical Measures Sheet – to health home teams, typically to PCN RNs/OHPs and PCN physicians and nurse practitioners. These sheets frequently become the starting point for clinical practice improvement work. A secondary opportunity this data provides is in aggregating the extracted EMR data at a regional level to support *measurement for accountability*. This supports annual reporting and regional evaluation needs, and provides the PCN with specific measures to evaluate the success of co-location of the PCN's 61 Registered Nurses and Other Healthcare Providers (RNs/OHPs) in health homes to support teams led by PCN physicians and nurse practitioners.



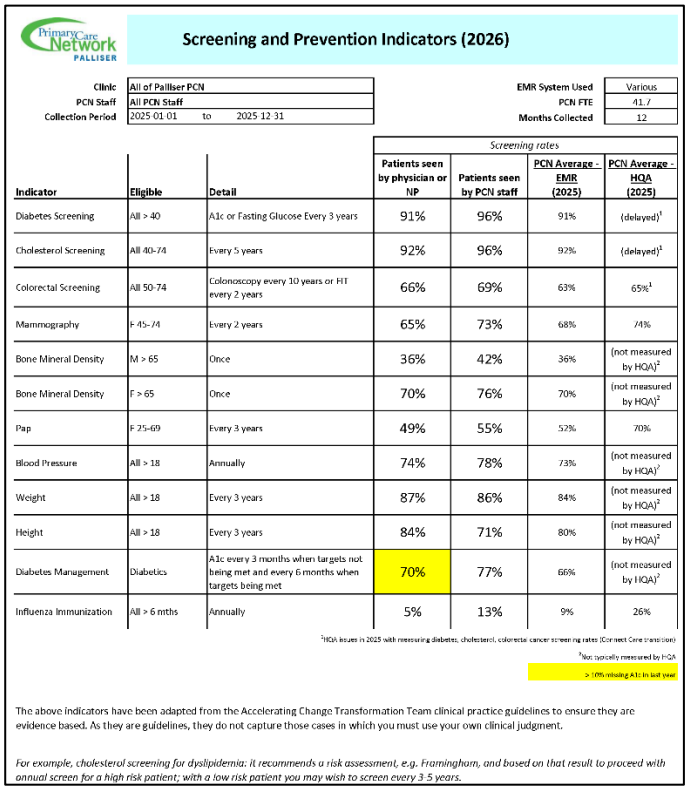


Figure 4 – 2025 PCN Activity and Measures Sheet: EMR-sourced data for PCN physicians, NPs, RNs/OHPs

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

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

[3] Alberta Health (2014). Alberta's Primary Health Care Strategy. https://open.alberta.ca/dataset/9781460108635
[4] Solberg, L I et al. "The three faces of performance measurement: improvement, accountability, and research." *The Joint Commission journal on quality improvement* vol. 23,3 (1997): 135-47. doi:10.1016/s1070-3241(16)30305-4

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

Figure 5 - Palliser PCN Physician and Nurse Practitioner Profiles Summary

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

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

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

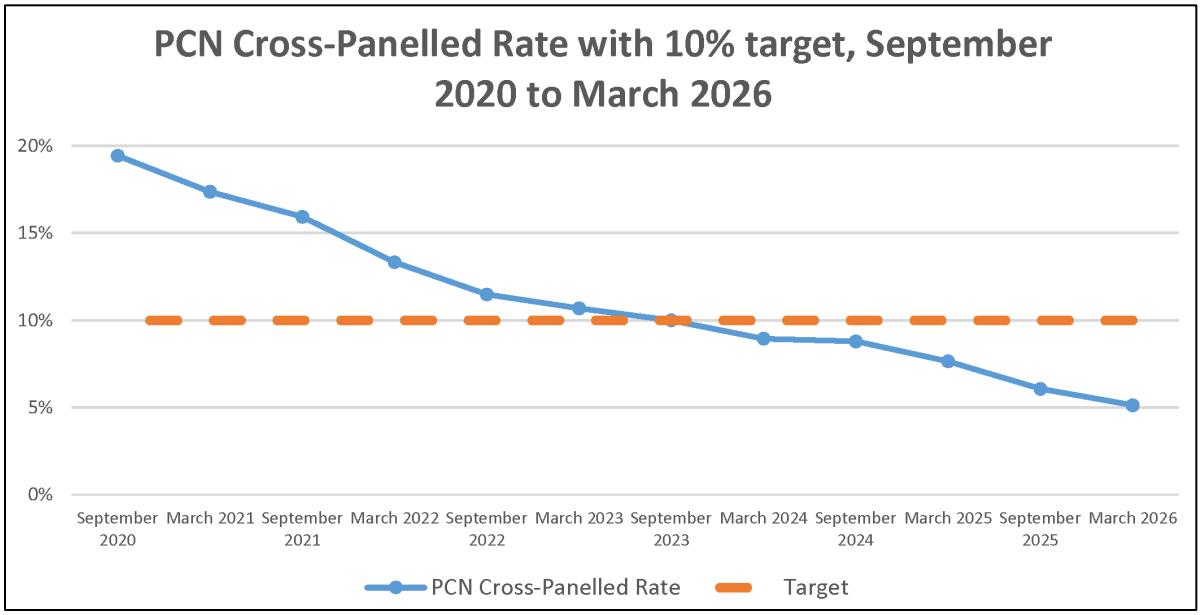


Figure 6 - Overall PCN Cross-Panelled Rate Over Time

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

Distribution of population with attachment status		**# of patients**
Total population estimate within Palliser PCN geographic area		121,000
Attached to Palliser PCN physicians' active family practice EMR panels		103,250
Attached elsewhere	Attached to a provider in an area not served by Palliser PCN	Negligible due to known patient preference / patterns
	Attached to non-PCN family doctors in the area served by the PCN	~3,000
Imminently attached	Will be attached to NPs	~1,500
	Capacity to be attached to PCN physicians currently accepting new patients	~3,000
Able to be attached after reduction in physician cross-panelled rate	Removing cross-panelled patients will provide capacity for existing PCN physicians to accept additional patients	~3,200
Unattached	**Seeking a family physician** in the area served by the PCN	**~7,050**
	Not seeking a family physician in the area served by the PCN	

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

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

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

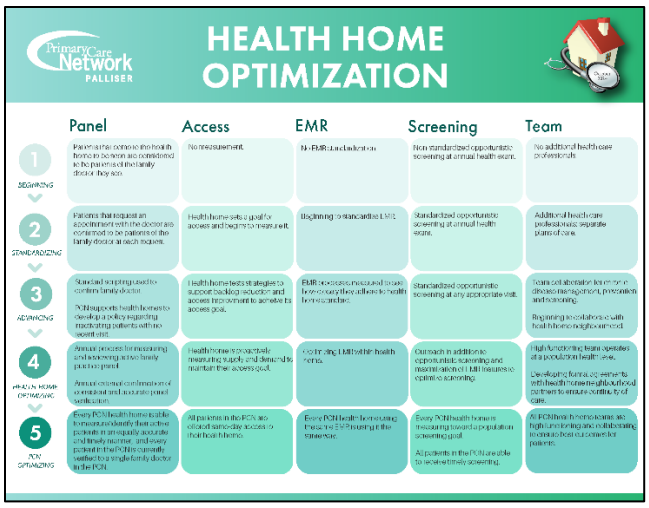


Figure 8 - Palliser PCN Health Home Optimization Model

Return on Investment

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

Basic Cost per Palliser PCN RN/OHP Patient Visit

$$Cost\ per\ Patient\ Visit = \frac{\text{Annual Revenue}}{\text{Number of Patient Visits per Year}} = \frac{\$6{,}490{,}000}{65{,}580} = \sim \$99\ per\ PCN\ RN/OHP\ visit$$

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

$$Cost\ per\ Unique\ Patient = \frac{\text{Annual Revenue}}{\text{Number of Unique Patients Seen per Year}} = \frac{\$6{,}490{,}000}{25{,}399} = \sim \$255\ per\ patient\ per\ year$$

Figure 9 - Palliser PCN Return on Investment Calculation Results

Compared to alternative return-on-investment calculations, the above calculations are simple and lend themselves to assessment against other organizations, their services and existing PCN funding at $62 per patient per year. A barrier the PCN has encountered to perform this comparative analysis is the lack of publicly available metrics from these organizations.

1.2. Period Overview

Name of Priority Initiative		Professional Support within Health Homes	
Element	**Planned Achievement**	**Status**	**Status Explanation***
Addition of RNs / Other Professionals to Physician Offices	Ongoing developments of interdisciplinary family practice teams/programs to support family practice in the delivery of services to patients. The resources available from the PCN are insufficient for each physician to manage all problems and therefore physicians will concentrate on those issues that are most applicable to significant numbers of their patients (most often this is chronic disease prevention and management.)	**On-going**	**1. Family Physicians:** The total number of participating physicians this reporting period is 90 (compared to budget of 97 physicians). **2. Other Health Providers:** Total FTE for this reporting period is 44.5 FTE, comprised of: 0.60 NP, 35.7 RN/LPN, 8.2 Behavioural Health Consultant (compared to budget forecast of 46.2 FTE). Average utilization: 60 minutes per patient. Access: 72% of submitted TNA values were 5 or fewer calendar days; 63% of TNA values were 3 or fewer days; 45% of TNA values were 0 or 1 days. Physician satisfaction: 91% physician and NP agreement with survey question regarding recommending working with RNs/OHPs to other physicians. Patient satisfaction: 94% overall satisfaction with care provided by RNs/OHPs. **3. Multi-disciplinary Teams** Percentage of physicians working in a health home teamlet integrated with PCN RNs/OHPs is 83%. For core family practice physicians: 87%. Explanation: All but five core family practice physicians are working in a health home teamlet with a PCN RN/OHP or are ready to recruit an imminent placement. These physicians are offered PCN staffing twice annually, at minimum, and additionally throughout the year when the opportunity presents. Minority family practice physicians not currently qualifying for PCN staffing are offered PCN practice improvement support to increase their panel size if they are interested in qualifying for PCN staffing.

<table>
<tr><th colspan="2">Name of Priority Initiative</th><td colspan="2">Measurement and Practice Improvement</td></tr>
<tr><th>Element</th><th>Planned Achievement</th><th>Status</th><th>Status Explanation</th></tr>
<tr><td>Implement measurement and practice improvement methodologies</td><td>Engage 5.0 FTE to support the development of the Health Home in participating clinics.

Key achievements include clinic team development, EMR optimization, identifying and optimizing clinic efficiencies, and clinic linkages with specialists and the community</td><td>On Target</td><td>
1. Practice Improvement Staffing

Two facilitators and three evaluation staff are currently supporting those clinics participating in practice improvement.

2. Collaborative Learning Sessions

From January 2024 to June 2025 (finishing during the reporting period), 10 health home teams (18 physicians and 34 clinic team members) embarked on the Health Home Expedition – an approximately 18-month collaborative learning series that delivered by quality improvement faculty that previously supported Alberta AIM and other longitudinal team-based collaborative QI initiatives. This Expedition was a customized approach to the local context, including the PCN’s priority focus on Access and Team-based care.

Expected outcomes from this collaborative learning series included increased team QI competency and increased Health Home Optimization (HHO) scores among health home teams.

• Participating team QI competency: 87% participant agreement with survey question regarding whether the Expedition enhanced knowledge, understanding and confidence in applying QI methods.

• Participating team HHO scores: 90% of participating health homes had an increased score in at least one HHO domain, with 70% improving in at least one of the PCN’s priority focus domains: Access and Team-based care.

• Administrative team QI competency: a further 58% of non-participating health homes also had an increased score in at least one HHO domain, although only 25% increased in Access and/or Team-based care, indicating Expedition participation did have a positive effect on improvements in the PCN’s priority focus domains.

Additionally, clinics are regularly exposed to non-collaborative-based practice improvement activities based on state of Health Home Optimization and their readiness for change.

3. Facilitated Education Events:

<table>
<tr><th>Event</th><th>Participants</th><th>Satisfaction</th></tr>
<tr><td>Primary Care Pearls
(April 1st,2025)</td><td>49</td><td>91%</td></tr>
<tr><td>Wellness Workshop
(May 14th, 2025)</td><td>49</td><td>89%</td></tr>
<tr><td>Health Home Expedition Session 5
(June 13-14, 2025)</td><td>34</td><td>81%</td></tr>
<tr><td>Mental Health Workshop
(September 24th, 2025)</td><td>49</td><td>92%</td></tr>
<tr><td>Obesity + Weight Management
(October 23rd, 2025)</td><td>49</td><td>91%</td></tr>
<tr><td>Autoimmune + Skin Conditions
(November 26th, 2025)</td><td>49</td><td>94%</td></tr>
<tr><td>Men’s + Women’s Health
(February 25th, 2026)</td><td>36</td><td>92%</td></tr>
<tr><td>Resource Expo Medicine Hat
(March 16th, 2026)</td><td>30</td><td>94%</td></tr>
</table>
</td></tr>
</table>

Resource Expo Brooks (March 24th, 2026)	10	94%

Figure 10 - Education Event Details and Satisfaction

4. **CPAR/CII enrollment:**

   At the end of the reporting period, CPAR/CII enrollment is at 93% among eligible core and minority family practice physicians and nurse practitioners.

5. **Minimization of PCN cross-panelled rates:**

   84% of core and minority family practice physicians and nurse practitioners have a PCN cross-panel rate under the PCN's target rate of 10% (up from 68% in the previous reporting period). 57% have a cross-panel rate under 5% (up from 39% in the previous reporting period).

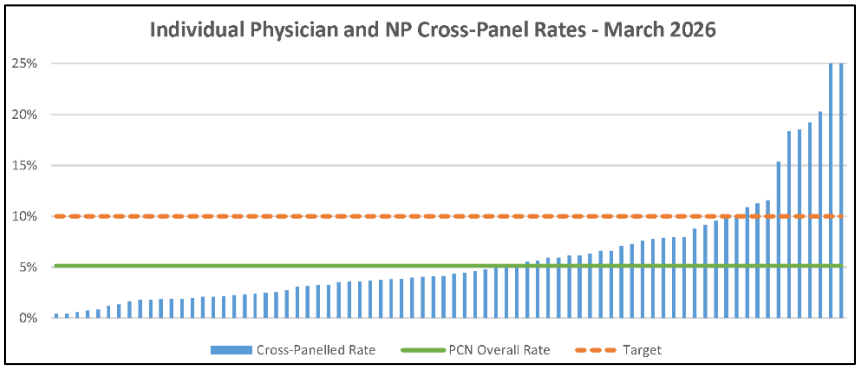


Figure 11 – Anonymous Individual Physician and NP Cross-Panel Rates, with 5.1% PCN Rate and 10% Target

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

2. EVALUATION

2.1. Contextual Questions

Question	Response	Comments
Does your PCN have an existing evaluation framework?	Yes	The PCN has a comprehensive Evaluation Framework which provides guidance for activities and evaluation within the PCN. Additionally, the PCN has a detailed Health Home Optimization conceptual model which is accompanied by a matrix of behaviors which can be expected at different stages of Health Home Optimization within clinics from Beginner to Expert (based on the Dreyfus model of skill development).

Does your PCN have an existing PCN-level logic model?	Yes	The PCN has an Evaluation Logic Model that supports its activities and evaluation. The AH Primary Health Care System Logic Model was used to inform the PCN Evaluation Handbook and Health Home Optimization conceptual model as described above.
Does your PCN have dedicated resources (e.g., FTE, funding) allocated to evaluation? *Identify resources*	Yes	Two facilitators and three evaluation staff are currently supporting those clinics participating in practice improvement
If answered "Yes" above, how have the evaluation processes been used to guide the improvement of program offering?	The PCN's Evaluation Logic Model and Framework guides the evaluation of its activities to meet the four PCN Provincial Objectives and align with the long-term primary care Provincial Outcomes (detailed in Section 1.1). As the PCN plans future activities and reassesses its current initiatives, it measures against relevant short-term and medium-term PCN outcomes and continually seeks to align each activity with at least one of the four PCN Provincial Objectives.	

2.2. Evaluation by PCN Objective

2.2.1. Objective 1 – Accountable and Effective Governance

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

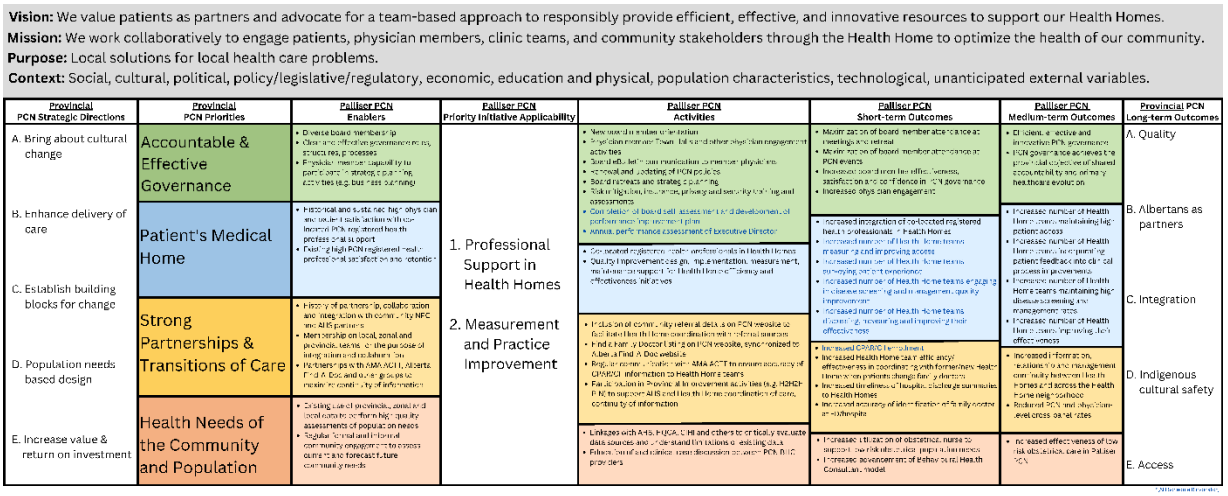


Figure 12 - PCN Evaluation Logic Model with Objective 1 activities circled.

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

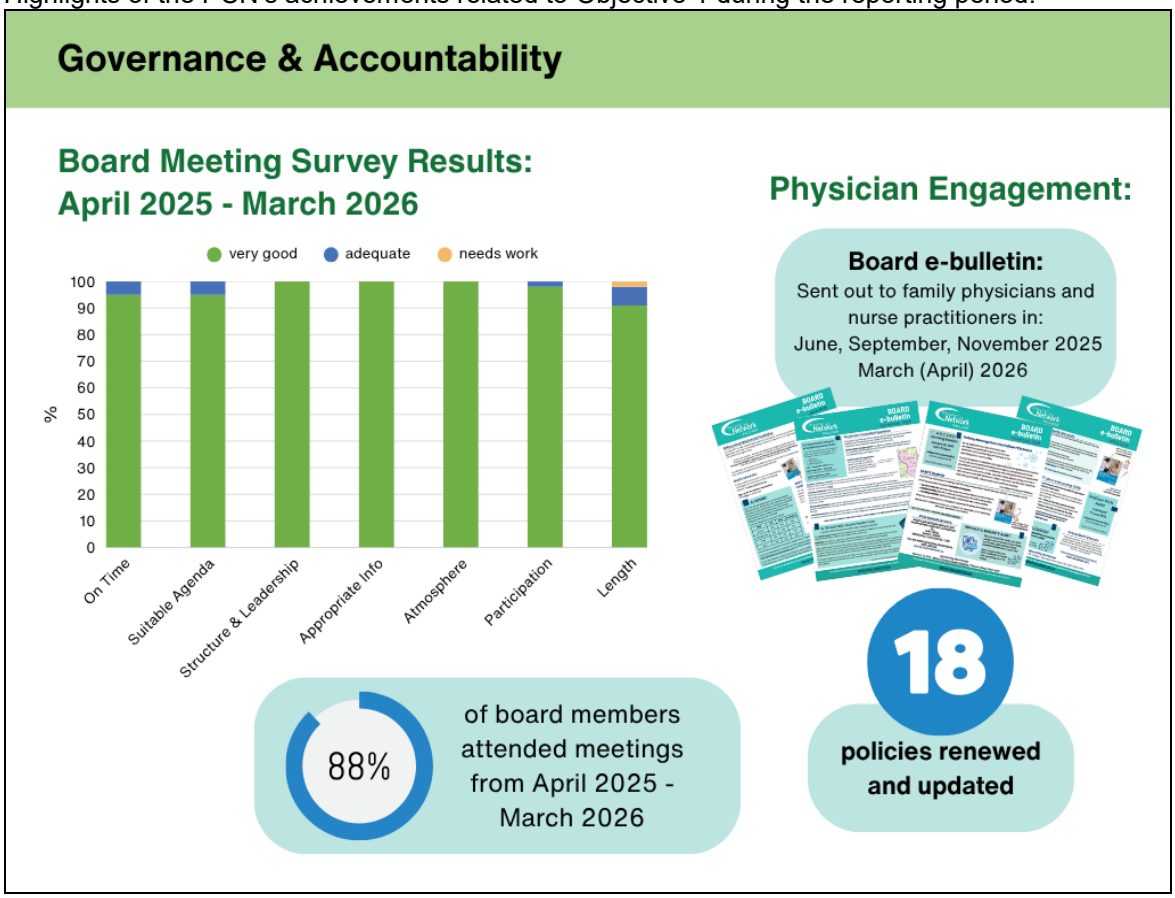


Figure 13 - Governance and Accountability Objective Highlights

Evaluation Activities

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

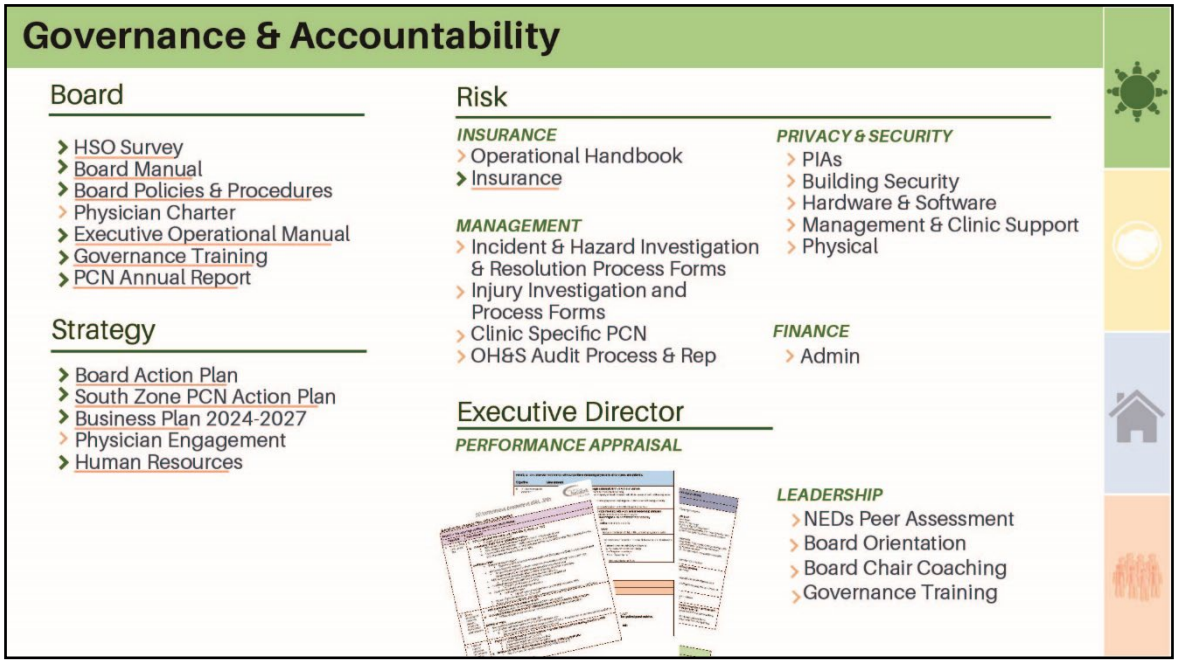


Figure 14 - Governance and Accountability Objective Activities
(performance appraisal detail not intended for legibility)

Details related to Objective 1 highlights:

- Example of PCN board accountability survey and attendance items reflected back to members
- Multiple activities during the reporting period to increase physician engagement: in-person and electronically
    - June 2025 Board e-bulletin: QI Award, Refocusing Ministerial Portfolios, 7 New RPHCNs, AI Scribe Grant
    - June 2025 Palliser PCN Physician Society AGM
    - September 2025 Board e-bulletin: MAPS Updates, AI Tools, Mobile Health Card
    - September 9, 2025: In-Person (Brooks and Medicine Hat) and Virtual Town Hall regarding Health System Transformation
    - November 2025 Board e-bulletin: MAPS Update, Remote Access Information, Privacy and Security with AI Products, PCN Board Holiday Message, Accuro Learning Session information.
    - March (April) 2026 Board e-bulletin: Parental Access to Health Records, CanREACH Fellowship, EMR Access Audit Reminder and Assistance, Prescribe It Closure
    - 2025-2026 Palliser PCN Facilitated Education Events:
        - January 22, 2026: In-Person Accuro Learning Session
        - Clinical Workshops - April, May, September, October, November 2025, February 2026
        - Resource Expos – Brooks (March 16, 2026) and Medicine Hat (March 24, 2026)
        - Health Home Expedition Session – June 2025

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

Outcome	Indicator	Measure
Maximization of board member attendance at meetings and retreat	• Percentage of board members attending board meetings	**88%**
	• Percentage of board members attending retreat	**N/A**
Maximization of board member attendance at PCN events	• Percentage of board members that attended a PCN event	**100%**
Increased board member effectiveness, satisfaction and confidence in PCN	• Individual post-board meeting survey	**Completed**
	• Executive Director performance assessment *[AH Schedule B indicator]*	**Completed**
Increased physician engagement	• Percentage of physicians who attended a PCN engagement event	**39%**

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

Barriers	Current uncertainty for PCNs has led to disengagement from board members and physician or NP members. Significant change management effort will be required to return to baseline operations before MAPS and/or transform the PCN into a different organizational structure. This will take time, human and financial resources.
Schedule B Indicator	• *Governance Indicator* Palliser PCN has engaged in governance training and goal setting for several years. The Accreditation Canada tool was used again in FY 25/26 and although improved from previous iterations it was still found to be minimally useful in improving governance training and goal setting compared to previous tools used.

GOVERNANCE INDICATOR	FY 2025/26	FY 2024/25
Did the PCN Non-Profit Corporation Board / Joint Governance Committee complete **both** the following activities during the year? 1) Collective self-assessment of the PCN Non-Profit Corporation Board / Joint Governance Committee as a whole. 2) Performance improvement plan for the PCN Non-Profit Corporation Board / Joint Governance Committee.	YES	YES
Did the Board use Health Standards Organization's Governance Functioning Tool in their self-assessment process?	YES	YES

Figure 16 - Governance Indicator

- *Leadership Indicator*

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

LEADERSHIP INDICATOR	FY 2025/26	FY 2024/25
Was a performance assessment completed during the year for the PCN Administrative Lead and all other staff members directly reporting to the PCN Non-Profit Corporation Board/Joint Governance Committee?	YES	YES

Figure 17 - Leadership Indicator

2.2.2. Objective 2 – Strong Partnerships and Transitions in Care

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

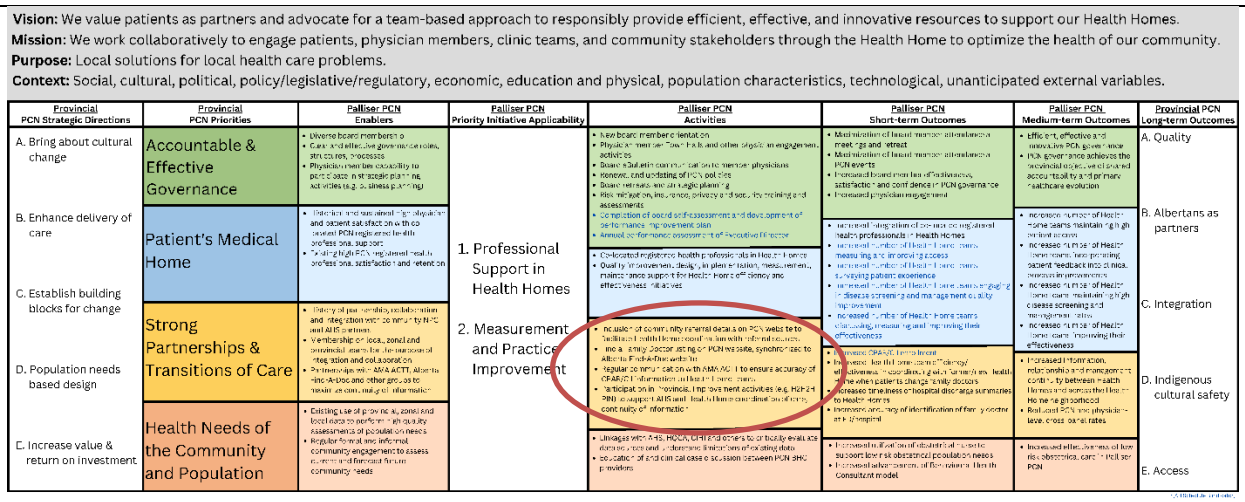


Figure 18 - PCN Evaluation Logic Model with Objective 2 activities circled

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

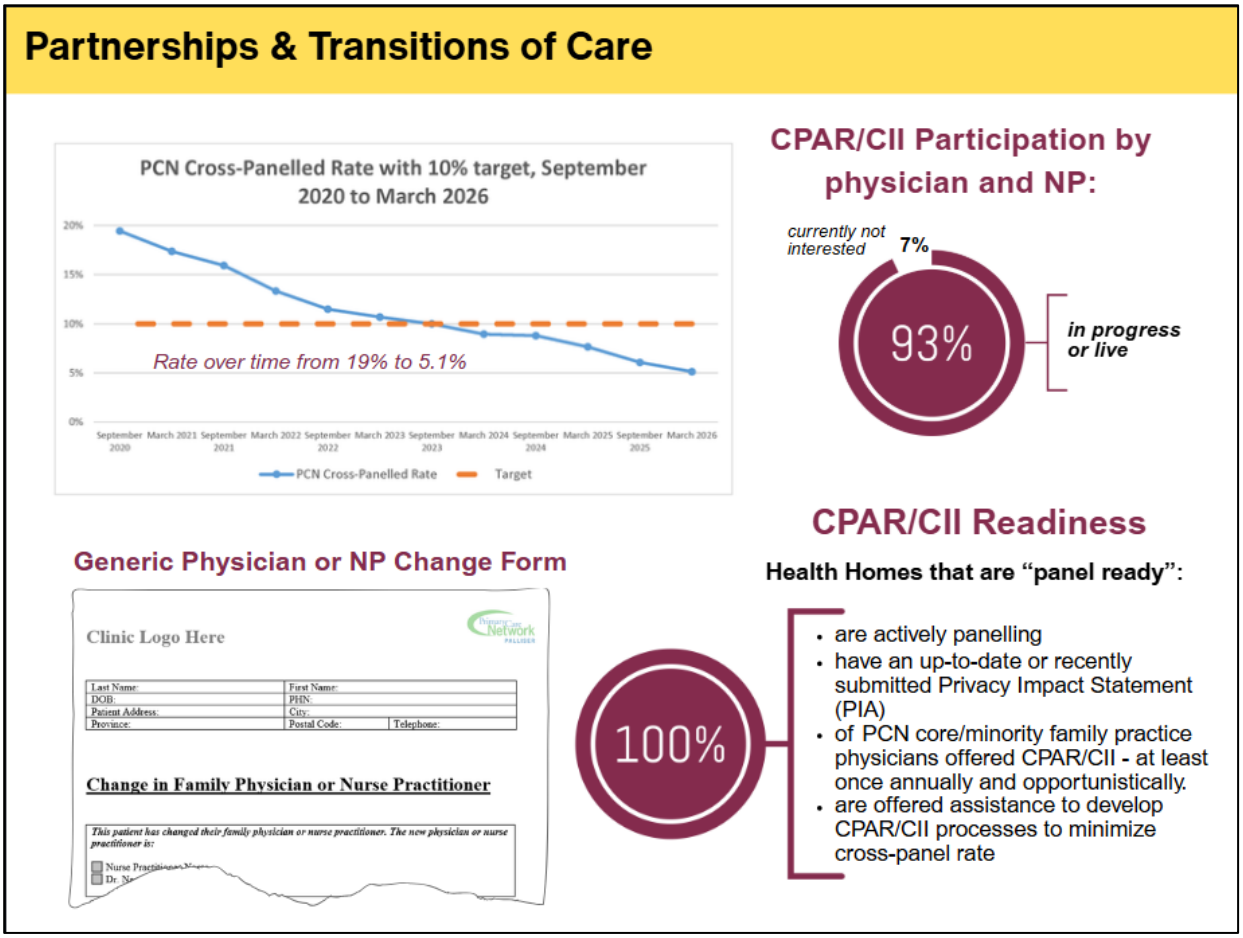


Figure 19 - Partnerships and Transitions of Care Objective Highlights

Evaluation Activities

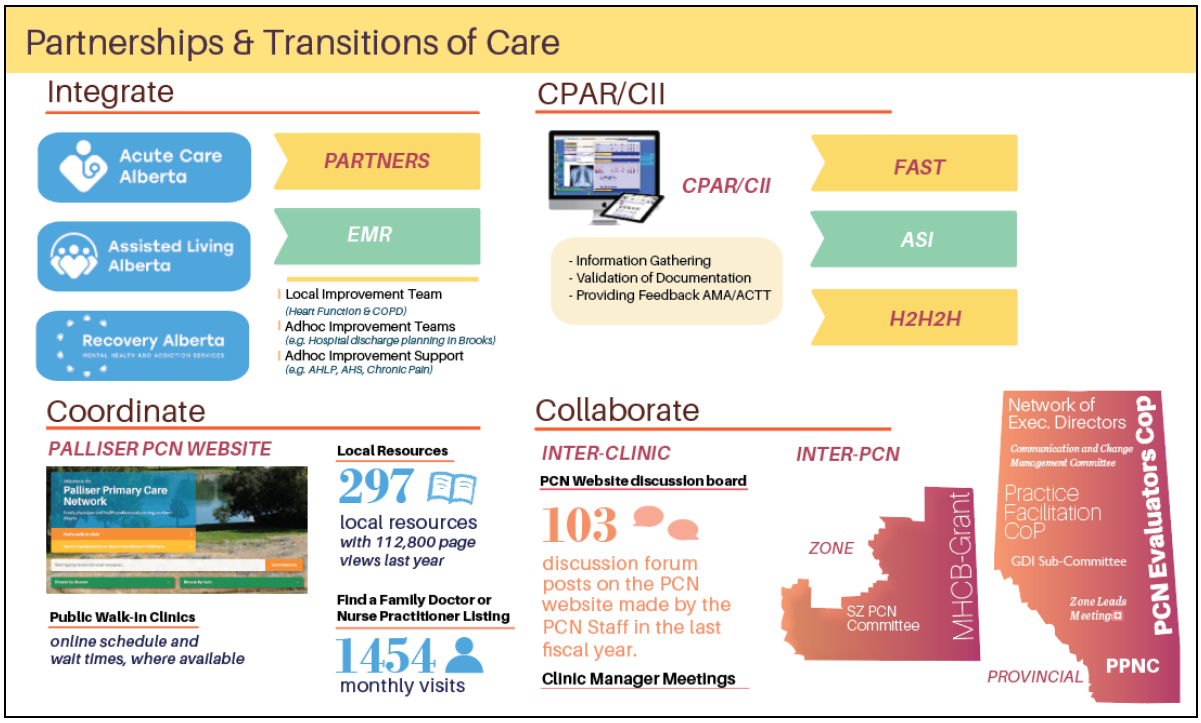


Figure 20 - Partnerships and Transitions of Care Objective Activities

Details related to Objective 2 highlights:

1. PCN has prioritized supporting member physician participation in CPAR/CII.
2. Panel readiness and CPAR/CII prerequisites have been met across health homes.
3. 72 physicians/nurse practitioners live or in-progress on CPAR/CII across 35 health homes
    - 93% of PCN physicians/nurse practitioners with active family practice panels
4. Increased interest in regularly using CPAR conflict reports anticipated with:
    - Increased PCPCM-participating physician interest in panel accuracy
    - Increased physician and nurse practitioner awareness of display of CPAR Primary Provider information in Netcare
    - Physician and nurse practitioner awareness of increased local participation in CPAR – increased completeness of conflict reports
5. Some methods used by Palliser PCN to approach physicians and teams to support increased use of CPAR conflict reports:
    - PCN staff meeting discussions, celebrating successes of participating teams in PCN Chronicles Newsletter, follow-ups from PCN staff performance appraisal process
    - Discussion at clinic manager meetings, discussion at individual physician member meetings
    - Topic included intermittently in Board e-Bulletin communications

Additional initiatives/achievements:

6. The existing physician or nurse practitioner office (including after-hours service), ER and Health Link resources provide appropriate 24-hour management of access.
    - PCN provides monthly updates to ER and walk-in clinics of family physicians accepting new patients; also updated on Palliser PCN website (10,100 annual page views)
    - PCN website connects to Alberta Find a Provider website to enable data synchronization between PCN website (source of truth) and AFAP website (secondary website)
        i. Annual AFAP website visits from visitors geo-located within Palliser PCN geographic area: 17,900 annual engaged sessions
        ii. Uncertain # of Palliser PCN patients visiting PCN website and AFAP website. Further, patients would be unaware that AFAP source data is the Palliser PCN website, i.e. AFAP website is redundant for Palliser PCN patients

7. Shared health record within physician clinic.
    - Ongoing optimization of EMR usage with family physician clinics supported by PCN Central Office Administration team
    - 100% remote access to health home EMRs for Evaluation and Improvement purposes
8. Increased awareness of and access to transition supports.
    - Optimization of the use of electronic referral documents integrated into health home EMRs, adoption of electronic referral processes e.g. eFax, internal EMR e-referral
    - 297 Community Resources listed on Palliser PCN website: bidirectional communication between PCN and community services ensures website is up-to-date and accessible
        i. Examples include caregiver support groups, newcomer supports, day programs, financial support
    - Third-party supports, e.g. Alberta Facilitated Access to Specialized Treatment (FAST) Program
        i. Physician and NP awareness of FAST Program is high, but local adoption of Alberta FAST Program is limited due to reliance on personal relationships between health homes and specialists. Communication regarding rollout is carefully managed to avoid saturation of health homes with future anticipated rollout timelines.
        ii. Physician perception of bureaucratic primacy reduces trust and adoption. E.g. lack of FAST team exercising clinical judgment when referral prerequisites are overdue, such as a baseline x-ray 93 days ago as opposed to 90 days ago.
9. AHS and community NPC partnering via workshops, staff meetings, online discussion board, and face-to-face front line provider interactions.
    - AHS attends the Palliser PCN fall staff meeting to provide updates on influenza immunization including provisioning process and troubleshooting
    - Other AHS programs and community NPCs attend staff meetings on an ad hoc basis including:
        i. Wellspring Alberta – Cancer Support
        ii. Dr. Leon Greef – Lifestyle Rx (Calgary)
        iii. Recovery Alberta Intensive Outreach & Diversion Services
        iv. Alberta Healthy Living Program – RN Prescribing
        v. Foothills Medical Centre - Adult Gender Clinic (Calgary)
        vi. Alberta Healthy Living Program – Chronic Pain
        vii. Alzheimer Society of Alberta
10. Increase linkages with existing zone programs (including secondary, tertiary, and long-term care services)

Where the PCN identifies a gap in service or learning need, the PCN provides clinical learning opportunities for health home teams, ensuring local service providers are considered in relevant education activities.

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

Short- or Medium-Term	Outcome	Indicator	Measure
Short	Increased CPAR/CII enrollment	• Number and percentage of physicians and NPs who enrolled in CPAR/CII *[AH Schedule B indicator]*	72 (**93%**) live or in progress
		• Associated CPAR/CII readiness indicators *[AH Schedule B indicator]*	Collected in CPAR Schedule B data table
	Increased Health Home team efficiency/effectiveness in coordinating with former/new Health Home when patients change family doctors or nurse practitioners	• Number and percentage of health homes that use a Physician or Nurse Practitioner Change Form when patients change family doctors or nurse practitioners	38 (**95%**) using a Physician or Nurse Practitioner Change Form
	Increased timeliness of hospital discharge summaries to Health Homes	• Distribution of delays between hospital discharge and receipt of Health Home hospital discharge summaries, per hospital	Delayed health system transformation has impeded progress on this item.
		• Opportunity for AHS/ACA/PCA collaboration to define a hospital discharge timeliness indicator	Delayed health system transformation has impeded progress on this item.
	Increased accuracy of identification of family doctor at ED/hospital	• Number and percentage of times incorrect identification of family doctor occurred	Delayed health system transformation has impeded progress on this item.
		• Opportunity for AHS/ACA/PCA collaboration to measure ED/hospital admission family doctor identification processes at ED/hospital	Delayed health system transformation has impeded progress on this item.
Medium	Increased information, relationship and management continuity between Health Homes and across the Health Home neighbourhood	• PCN average physician and clinic continuity	**77%** physician and **85%** clinic continuity: *HQA PCN Proxy Report 2026*
		• H2H2H implementation measures	Delayed health system transformation has impeded progress on this item.
	Reduced PCN and physician-level cross-panel rates	• PCN overall cross-panel rate	**5.1%**
		• Number and percentage of physicians in each stratification of cross-panel rate (< 5%, 5-10%, 10-20%, >20%)	<5%: 43 (**57%**) 5-10%: 21 (**27%**) 10-20%: 9 (**12%**) >20%: 3 (**4%**)

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

Barriers	Some health home supports (e.g. Connect Care, CPAR/CII, FAST, Netcare, EMR vendor products) indicate a promise of services that are not currently or universally accessible to Palliser PCN health home teams. This is related to geography, cost, IT literacy and system IT infrastructure. Some of the same supports (e.g. FAST) come with additional barriers, such as perception of increased administrative burden, bureaucratic primacy, lack of clinical judgment included in support. FAST barriers discussed in above Evaluation Activities section. Additional engagement with CPAR conflict reports anticipated with: • Increased physician and NP interest in reducing Palliser PCN cross-panel rate, in order to improve panel accuracy and increase ability to define panel needs for incoming PCN RN/OHP (as providers newly qualify for PCN RN/OHP) • Increased physician participation in PCPCM, causing increased interest in panel accuracy to optimize panel payments • Increased physician and NP awareness that CPAR Primary Provider(s) is displayed in Netcare • Increased health home experience with unexpectedly receiving CII eNotifications for conflict patients • Provider awareness of increased local participation in CPAR – increased value of conflict reports ○ With 93% Palliser PCN physician and NP participation, approximately 87% of all within-PCN conflicts are able to be seen in CPAR conflict reports[5]. This is higher than previously reported numbers (80% in last reporting period, 57% in 2023-24), indicating higher regional utility for CPAR conflict reports. Stalled health system transformation activities have prevented progress in: • Increasing timeliness of hospital discharge summaries to Health Homes • Increasing accuracy of identification of family doctor at ED/hospital • Increasing information, relationship and management continuity between Health Homes and across the Health Home neighbourhood In the reporting period, the PCN was not able to locate local acute care partners to collaborate on H2H2H QI activities described above, including baseline measurement, comparison of acute care vs. health home data, and tests of change. Should there be a sudden increase in collaboration, the PCN's leadership capacity will need to expand to accommodate the demand.
Schedule B Indicator	None indicated in Annual Report Guidelines; CPAR-related Schedule B indicators are described throughout, including in above areas of Section 2.2.2 as well as in pillar 4g of Section 2.2.4.

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

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

[5] Wagen, et al. "How to Calculate the Number of Wires for a Fully Meshed Network." X, x-engineer.org/wires-fully-meshed-network/. Accessed 4 June 2026.

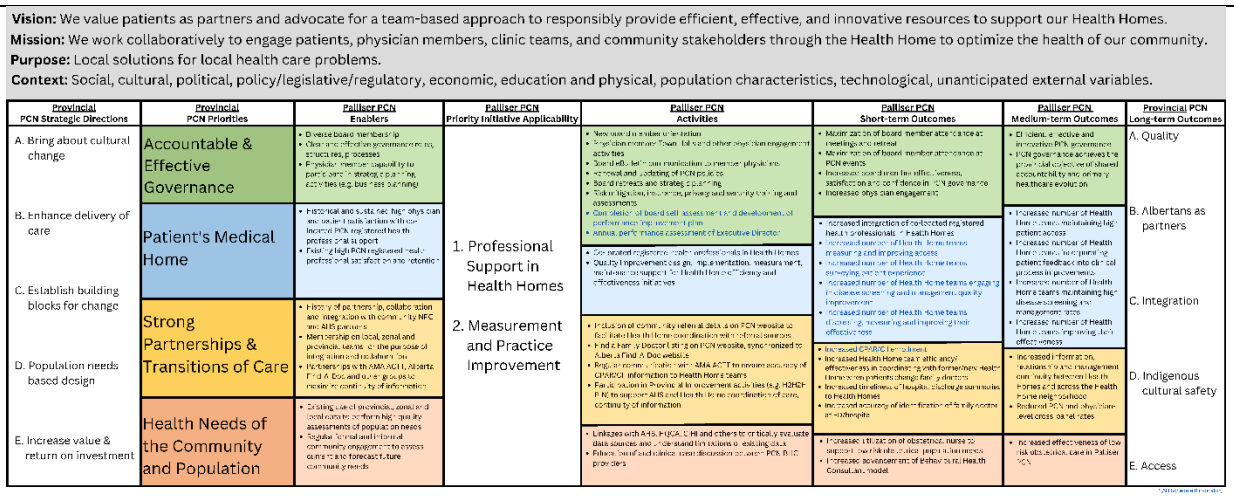


Figure 22 - PCN Evaluation Logic Model with Objective 3 activities circled

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

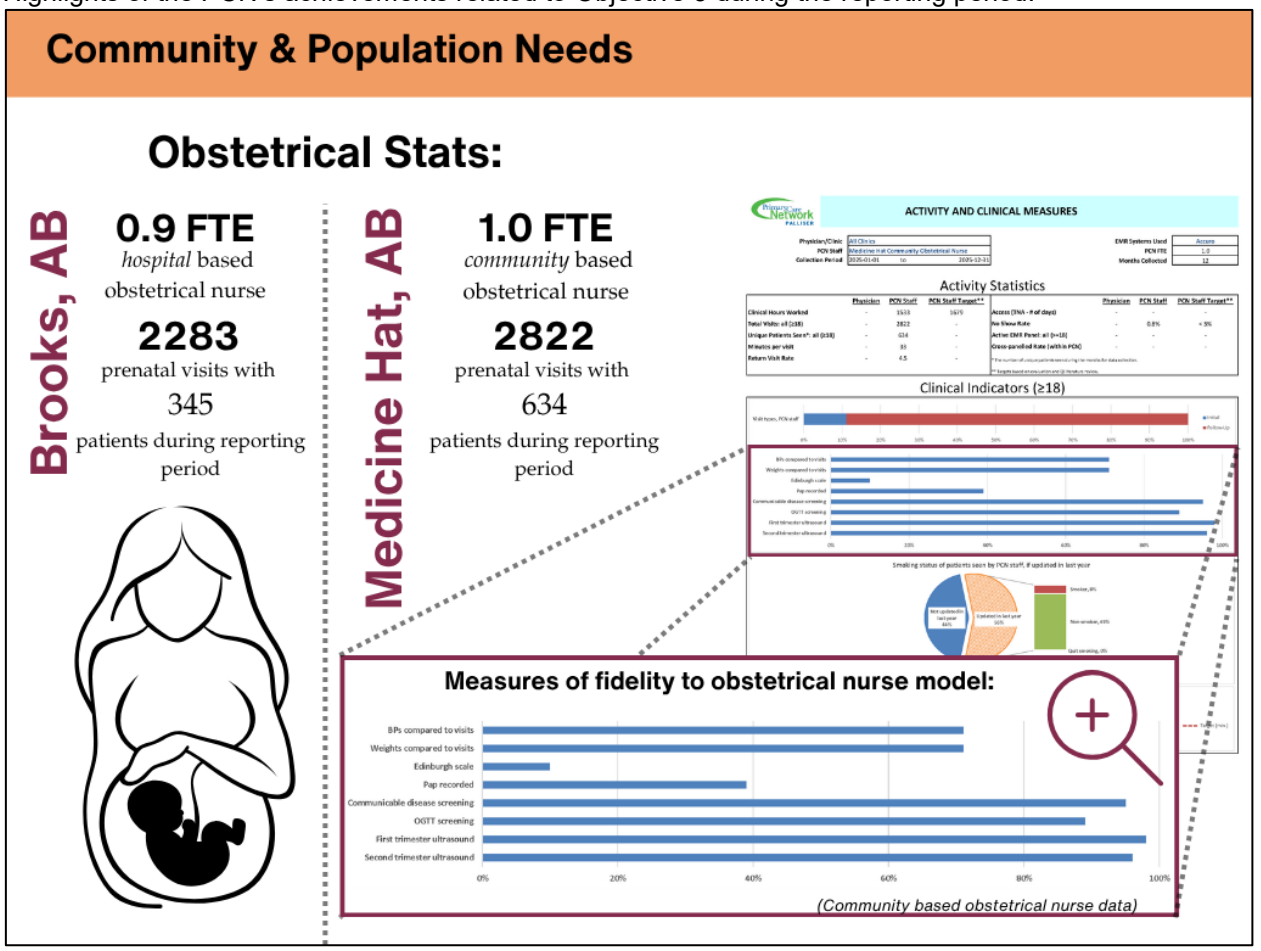


Figure 23 - Community and Population Needs Objective Highlights

During the reporting period, the PCN supported a nurse practitioner to work in a community pharmacy in Medicine Hat, to improve access for unattached and vulnerable patients, providing health counseling, client education and comprehensive assessments. The 0.6 FTE NP provided same-day access and saw 592 patients during the reporting period for a total of 1142 visits. Based on hours worked, the utilization was approximately 48 minutes per visit (or approximately 9.4 visits per fulltime day). Other collected data is seen on the next page:

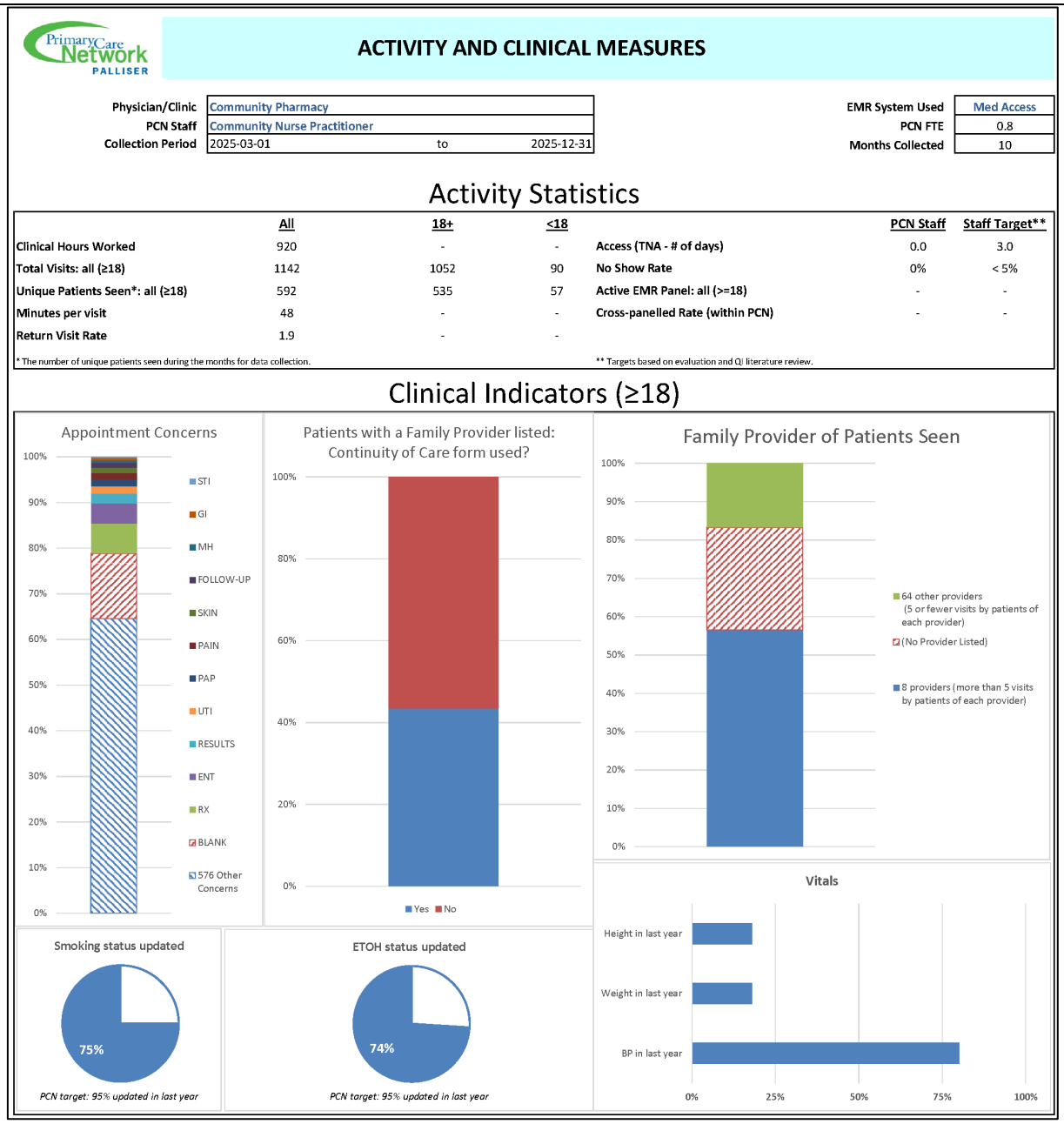


Figure 24 – Community NP Activity and Clinical Measures Sheet, 2025

Although one goal for the community NP was to improve access for unattached patients, only 27% of patients seen had no family provider identified. Among the remaining 73% of patients, these were primarily patients of 8 different family providers. Potential reasons for increased utilization among patients of these providers: advertisement of community NP to these patients, location of community pharmacy, able to provide same-day access, family provider not performing work otherwise associated with family practice (e.g. pap, ear irrigation).

In January and February 2026, the PCN leadership and a board representative participated in weekly two-hour PCA-led meetings surrounding the Target Operating Model (TOM) for RPHCNs. These meetings included discussions of population needs for physicians and nurse practitioners accepting new patients. The PCN most recently measured this information in October 2025, seen on the next page:

Distribution of population with attachment status		# of patients
Total population estimate within Palliser PCN geographic area		121,000
Attached to Palliser PCN physicians' active family practice EMR panels		103,250
Attached elsewhere	Attached to a provider in an area not served by Palliser PCN	Negligible due to known patient preference / patterns
	Attached to non-PCN family doctors in the area served by the PCN	~3,000
Imminently attached	Will be attached to NPs	~1,500
	Capacity to be attached to PCN doctors currently accepting new patients	~3,000
Able to be attached after reduction in physician cross-panelled rate	Removing cross-panelled patients will provide capacity for existing PCN physicians to accept additional patients	~3,200
Unattached	**Seeking a family doctor** in the area served by the PCN	**~7,050**
	Not seeking a family doctor in the area served by the PCN	

Figure 25 – Palliser PCN regional population distribution and attachment – October 2025

Engaging in this measurement:

- enables data-informed population and workforce planning that includes consideration of patient access (e.g. Figure 25's "able to be attached to PCN doctors currently accepting new patients" measure considers individual provider supply and demand context)
- facilitates a fulsome engagement with provincial entities that estimate unattached patients (e.g. AMA[6])
- socializes a differentiation between patients who may be inadvertently considered to be "unattached" and those who do not have a family doctor or nurse practitioner, when a data source is unable make this distinction (e.g. Calgary Rural PCN unattached patient screening program)
- assists AHS in its local planning responsibility for family practice provider recruitment.

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

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

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

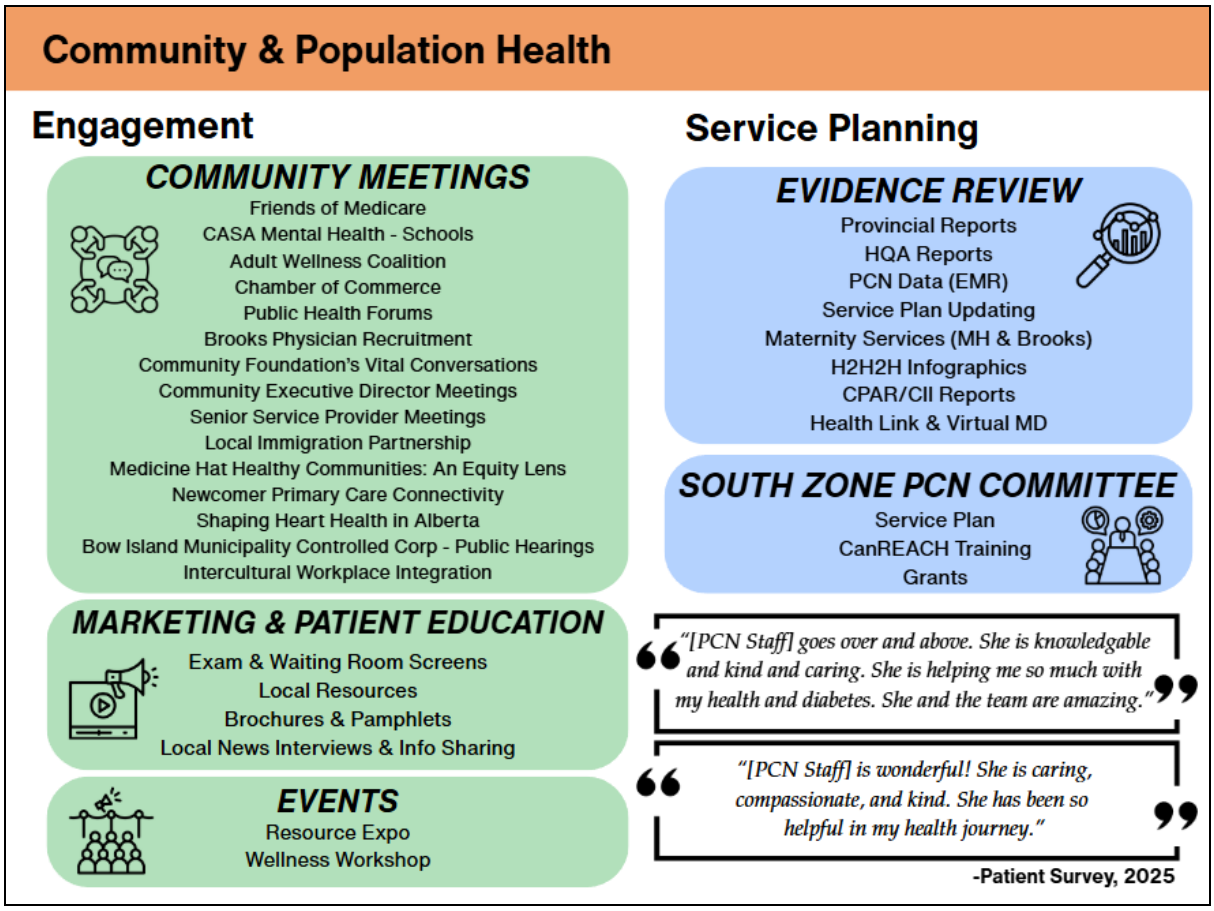


Figure 26 - Community and Population Health Objective Activities

Details related to Objective 3 highlights:

- PCN airborne illness support to health homes included:
  - N95 mask fit testing for PCN RNs/OHPs; offered to PCN physicians and clinic staff, and dissemination of key messages to health home teams
  - Support with patient messaging, including regular updating of local measles exposure advisories on 60 waiting room and exam room screens located in 26 health homes
- 1.0 FTE community obstetrical nurse utilized to support prenatal care in Medicine Hat and co-located in three health homes, supported prenatal visits including referrals for necessary screening and completion of Alberta Prenatal Record

Additional initiatives/achievements:

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

- Access
- Screening
- Transitions
- Health management

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



Figure 27 - Palliser PCN Collaboration Activities

5. Advancement of the Behavioural Health Consultant (BHC) model
    - 9 distinct BHC staff during the year, 4.9 FTE at the end of this reporting period
    - Using PHQ-9, GAD-7, BHC-7 (Palliser PCN-developed) and Burns Anxiety/Depression Inventory Assessments (*Patient Reported Outcome Measures – PROMs*) for clinical care:
        - 5,694 BHC visits with 1,619 patients in the reporting period
            - 984 Initial and 4,400 Follow-up visits
        - 4,655 BHC-7 Questionnaires completed during these visits
            - With an expectation of a BHC-7 completed during each BHC initial and follow-up visit, model fidelity during the reporting period is estimated at 86%.
            - This is higher than the previous reporting period's estimated model fidelity of 83% (2023/24: 90%) potential factors: individual improvement work on BHC model fidelity, supported by PCN facilitators, increased BHC familiarity/comfort with model
            - Individual BHC staff review this measure (comparison of BHC visits to BHC-7 assessments) during their annual performance assessment. Staff supported to identify barriers that occurred during the reporting period and set practice improvement goals with support of PCN facilitators and supervisors.
        - Additionally, 4,762 PHQ-9 and 3,682 GAD-7 assessments completed by patients who saw these providers.
    - BHC checklists and EMR charting workflows refined during the reporting period (e.g. charting template enhancement, including reminder to ask patient about last flu shot).
    - Summary of BHC information seen in Figure 28 on next page.
6. EQ-5D *PROM* collection continued for all non-BHC PCN clinical staff during this reporting period.
    - Practice Improvement Facilitators continue to assist PCN staff to develop PDSAs to maximize EQ-5D assessments (e.g. embedding into EMR workflows to increase clinical utilization, adding to clinical care checklists where these are used) to achieve goal of one EQ-5D assessment per patient per year.
    - 13,800 EQ-5D scores for different patients were collected during the reporting period.
    - Compared to 12,500 EQ-5D scores in 2024/25, 10,300 EQ-5D scores in 2023/24, 11,300 EQ-5D scores in 2022/23, 15,900 EQ-5D scores in 2021/22, 12,500 EQ-5D scores in 2020/21, 5,800 EQ-5D scores in 2019/20, 3,700 EQ-5D scores in 2018/19
    - 10% increase in EQ-5D collection since previous reporting period. Potential reason: further stabilization of EQ-5D collection processes after EMR migrations to Ava EMR during the 2023/24 reporting period and continued quality improvement work.
    - Potential barrier to increased collection: perception of this PROM as minimally micro-level[7] oriented. This compares to BHC-7, PHQ-9 and GAD-7 PROMs used by PCN BHCs: developed and incorporated into PCN workflows as PROMs that straddle both micro and meso level usages; potentially correlated with substantially higher adoption.
7. Crisis Prevention Institute Nonviolent Crisis Intervention and Prevention First Training
    - CPI training continues to be held on an ongoing basis as needed. Certificate is good for 3 years.
8. Facilitate patients seeking a family doctor or nurse practitioner with access to accurate information regarding family doctors or nurse practitioners accepting new patients.
    - PCN updates a listing of doctors and nurse practitioners accepting new patients every month.
    - 17,450 annual visits to this listing on the "Find a family doctor or nurse practitioner accepting new patients" link on PCN website homepage.
    - During the reporting period, an average of 10 family physicians and nurse practitioners were accepting new patients at any time. This matches the previous reporting period.
    - PCN supports AFAP data harmonization with API connection sending Palliser PCN website updates (primary source) to AFAP.

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

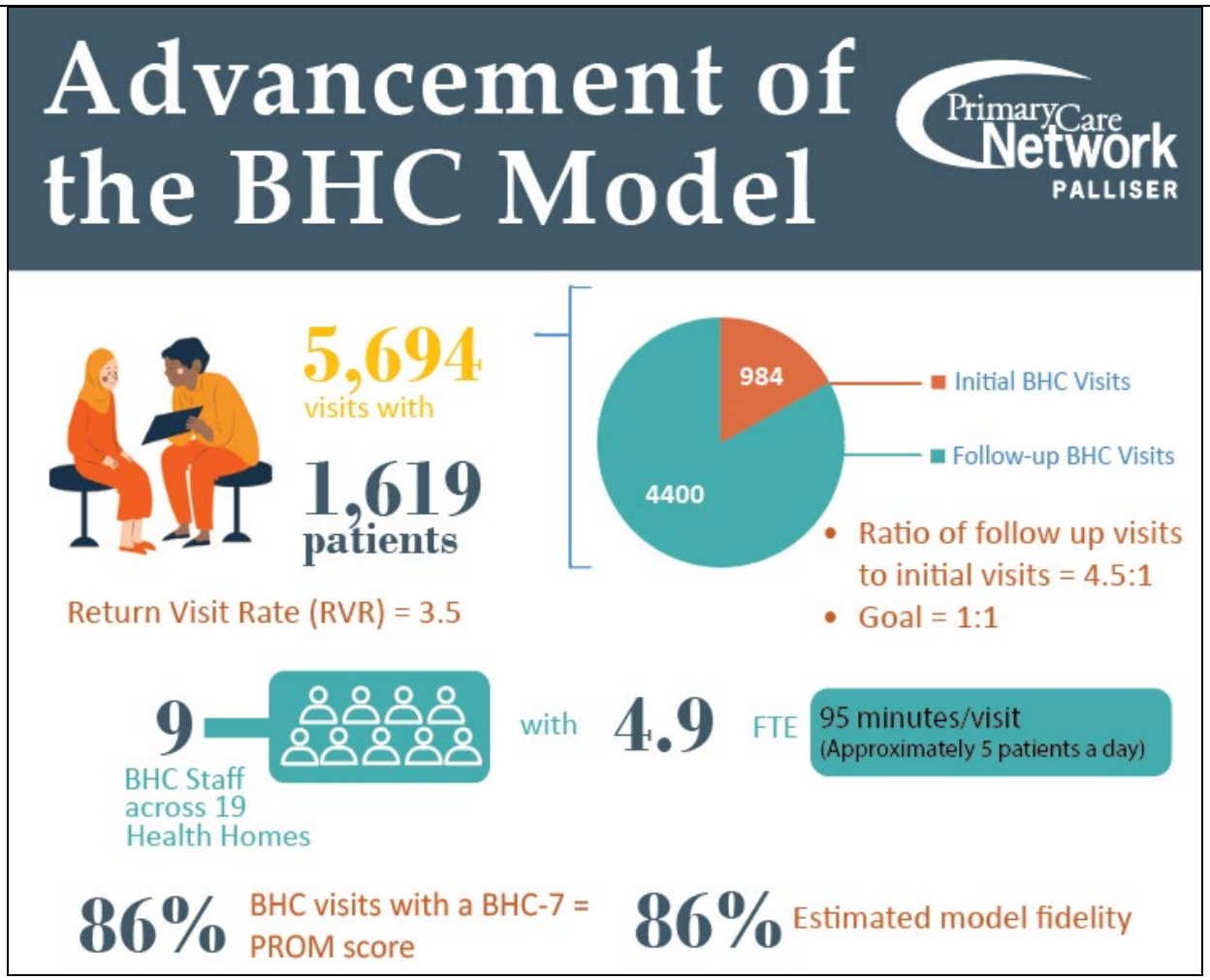


Figure 28 - Advancement of the BHC Model

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

Short- or Medium-Term	Outcome	Indicator	Measure
Short	Increased utilization of obstetrical nurse to support low risk obstetrical population needs	• Number of unique patients and visits by obstetrical nurse	**979** obstetrical patients seen for **5105** visits (Medicine Hat and Brooks obstetrical nurses)
	Increased advancement of Behavioural Health Consultant model	• Number of unique patients and visits by PCN BHC providers	**1619** patients seen for **5694** visits
		• Number of visits with BHC-7, PHQ-9 and GAD-7 assessments occurring	BHC-7: **86%** of visits; PHQ-9: **88%** of visits; GAD-7: **68%** of visits
Medium	Increased effectiveness of low risk obstetrical care in Palliser PCN	• Fidelity measures to obstetrical nurse model (vitals, disease screening, ultrasound)	BPs: **71%** of visits; Weights: **71%** of visits; Pap: **39%** of patients; Communicable disease screening: **95%**; OGTT: **89%**; First trimester ultrasound: **98%**; Second trimester ultrasound: **96%** (Community obstetrical nurse)

			• Opportunity for collaboration with AHS to define a low-risk obstetrical care effectiveness indicator	Delayed health system transformation impeded progress on this item.

Figure 29 – PCN Evaluation Indicators for Objective 3 (Community and Population Health)

Barriers

1. Health workforce supply
    - All professions; shortage in workforce size and reduction in existing workforce wellness
    - Emerging workforce strives for fewer hours of work (work-life balance)
2. Health workforce preference changes causing reduction in breadth of care
    - Special interests (e.g. sports medicine, cosmetic, women's health) may require increased attention to continuity of care, information and management
    - Not working to full scope/not performing work otherwise associated with family practice (e.g. pap, ear irrigation, skin) may require additional coordination of care
3. Addition of modes of care, e.g. 811, community pharmacists, walk-in clinics, Virtual MD
    - May require increased attention to continuity of care, information and management
    - May require increased attention to balancing measures, e.g. access, primary/secondary screening and management, to ensure equal attention to short-term gains and medium-term outcomes (e.g. increased short-term access with decreased medium-term screening across the continuum of care)
4. Challenges in deriving actionable community and population health information from data sources that vary in:
    - Age: e.g. Current Alberta Health "PCN Dashboard" accessed in June 2026 was last updated in March 2023, but data ends March 31, 2021
    - Level of aggregation – data not always specific to PCN or community: e.g.
        i. some Alberta Health Community Profile data cannot be drilled down beyond the zone level, other data cannot be subdivided beyond the LGA, down to individual cities/towns
        ii. Health Link 811 Nursing and Virtual MD statistics are only reported at a South Zone level: this data gap prevents the PCN from meaningfully probing utilization and utility for population residing in its geographic region

Schedule B Indicator

The PCN's use of the EQ-5D Patient Reported Outcome Measure is described in the above Evaluation Activities section. The PCN also uses other PROMs to evaluate its Behavioural Health Consultant model (BHC-7, PHQ-9), described further above.

EQ-5D PROM collection continued for all non-BHC PCN clinical staff during this reporting period.

13,800 EQ-5D scores for different patients were collected during the reporting period.

Practice Improvement Facilitators continue to assist PCN staff to develop PDSAs to maximize EQ-5D and BHC PROM assessments (e.g. embedding into EMR workflows to increase clinical utilization, adding to clinical care checklists where these are used, using patient portals to prompt patients to complete assessments in advance of their visit) to more closely approach the ideal of 100% BHC model fidelity and one EQ-5D assessment per patient per year.

2.2.4. Objective 4 – Patient's Medical Home (PMH)

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

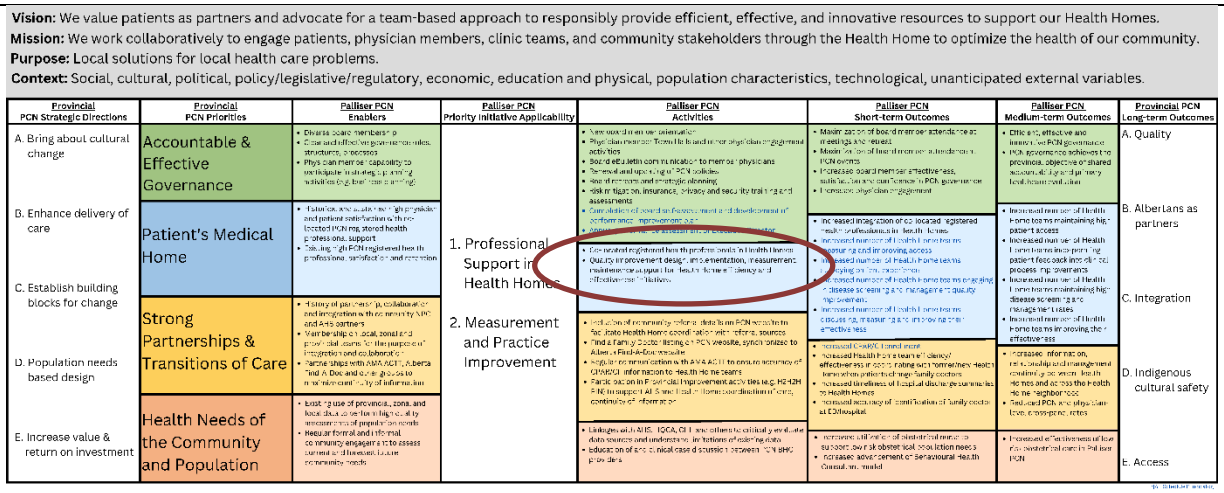


Figure 30 - PCN Evaluation Logic Model with Objective 4 activities circled.

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



Figure 31 - Patient's Medical Home Objective Activities

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

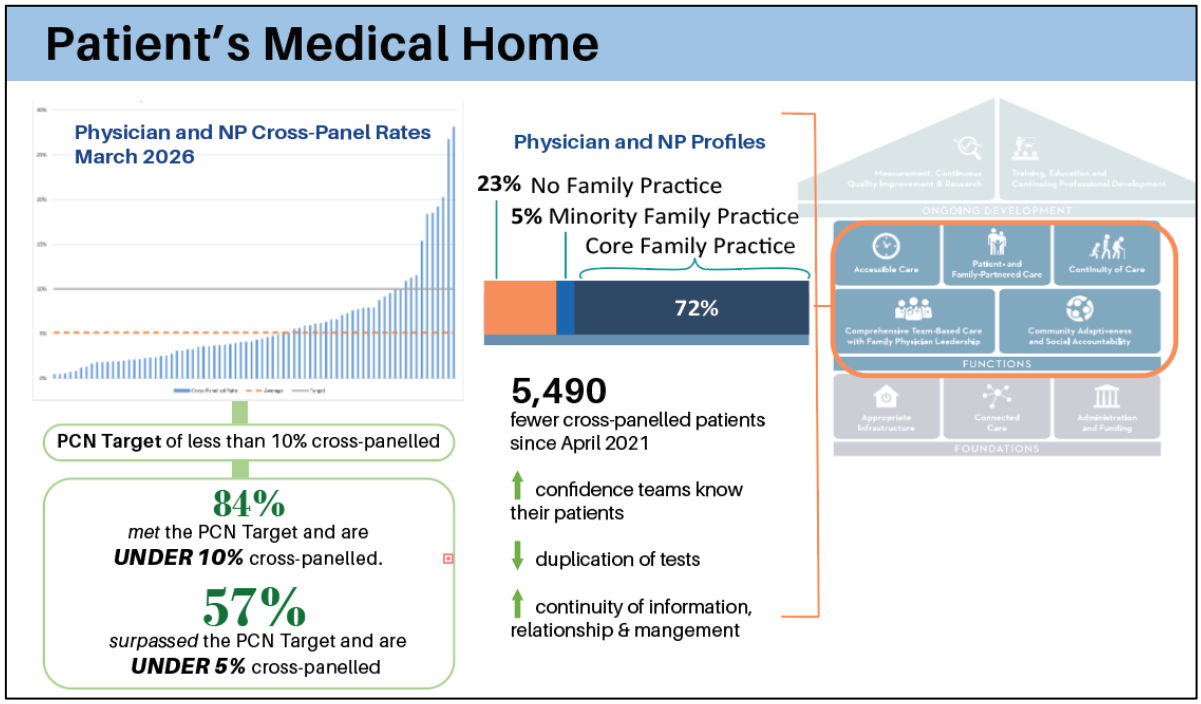


Figure 32 – Patient's Medical Home Objective Highlights

Details related to Objective 4 highlights:

- Measurement of the EMR family practice panel excludes cross-panelled patients (5.1% of patients at the PCN level, compared to 7.7% in FY 2024-25, compared to 8.9% in FY 2023-24,

11% in FY 2022-23 and 13% in FY 2021-22). I.e. patients that are on more than one EMR family practice panel are excluded from calculation.

- The PCN offers strategies and support to all health homes (physicians & NPs) to increase and/or stabilize their panel numbers, including to those physicians who will need to make an FTE reduction and have a two-year notice period in which they are supported to increase their panel. This includes supporting teams to review panels, contact patients, and administratively inactivate patients who have not been in to the clinic in three years. (Typically, three years is chosen as patient fidelity to a health home has been experientially noted to drop off significantly if a patient has not presented during this time). These strategies combine to develop and sustain processes to buttress panel accuracy.
- Health homes that anticipated the addition of new physicians or NPs were supported to establish processes to clearly identify family practice patients as the new providers arrived – processes which align with the CPSA standards of practice regarding establishing the patient-provider relationship.
- Privacy in-services led by PCN facilitators support PCN staff and health home staff awareness of physical, technical and administrative safeguards to protect patient health information.
- Process improvement to utilize CPAR conflict reports is offered to all health home teams and framed as an activity that supports this work (see Objective 2 summary).
- Increasing panel accuracy and minimizing cross-panelled rate supports achievement towards the Patient's Medical Home Model functions of Continuity of Care, Accessible Care, Patient- and Family-Partnered Care, Comprehensive Team-Based Care, and Community Adaptiveness and Social Accountability.

Achievements and initiatives cross-referenced with related PMH pillars:

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

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

Outcome	**Indicator**	**Measure**	**Related Pillar(s)**
Increased integration of co-located registered health professionals in Health Homes	• Number of co-located registered health professionals in Health Homes and stratification of roles	61; by FTE, comprising 36 RN/LPN, 8.5 Behavioural Health Consultant and 0.60 NP	4a-4g
	• Number and percentage of Health Homes with access to a PCN registered health professional	35 **(88%)**	4a-4g
Increased number of Health Home teams measuring and improving access	• Number and percentage of physicians/NPs and PCN OHPs measuring Time to Third Next Available Appointment *[AH Schedule B indicator]*	86 physicians and NPs **(100%)** 61 PCN OHPs **(100%)**	4b, 4d, 4e
	• Number and percentage of Health Homes with a PCN Health Home Optimization (HHO) Model Access score of 2 or higher	8 **(20%)**	4b, 4d, 4e

	Increased number of Health Home teams surveying patient experience	• Number and percentage of teams surveying patient experience	Palliser PCN Patient Survey (patients who saw a PCN RN/OHP): **100**% of teams with a PCN RN/OHP; Health Home Patient Survey (patients who visited the health home): 2 **(5%)**	4c, 4e
		• Percentage of patients reporting "Excellent" or "Very Good" to last six months overall care survey question *[AH Schedule B indicator]*	**98%**	4c, 4e
	Increased number of Health Home teams engaging in disease screening and management quality improvement	• Disease screening and management activity completion rates *[AH Schedule B indicator]*	DM Screening: **91%**; Cholesterol Screening: **92%**; Colorectal Cancer Screening: **66%**; Breast Cancer Screening: **65%**; BMD Screening, males: **36%**; BMD Screening, females: **70%**; Cervical Cancer Screening: **49%**; Hypertension Screening: **74%**; Weight Screening: **87%**; Height Screening: **84%**; DM Management: **70%**	4c-4e
		• Number and percentage of teams with a HHO Screening score of 2.5 or higher	8 (**20%**)	4c-4e
	Increased number of Health Home teams discussing, measuring and improving their effectiveness	• Number and percentage of teams measuring team effectiveness *[AH Schedule B Indicator]*	Using mandated instrument: 5 (**13%**)	4d
		• Number and percentage of teams with a HHO Team score of 2 or higher	6 (**15%**)	4d

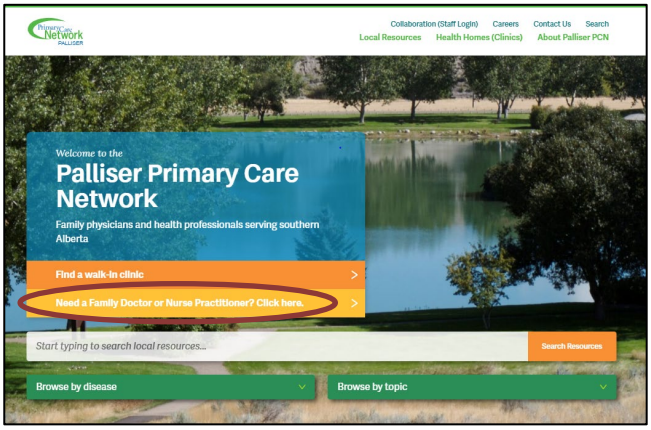
Figure 33 – PCN Evaluation indicators for Objective 4 (Patient's Medical Home)

4a	**Care Coordination**
Summary and/or Achievements	Please see discussion in Objective 2: Strong Partnerships & Transitions of Care for further details regarding Palliser PCN initiatives to advance this pillar. Highlight made above related to CPAR/CII readiness and participation support.
Evaluation Activities	The annual Palliser PCN physician survey contains a question regarding transitions of care. With feedback gathered through the PCN employee performance assessment process and PCN facilitator support offered to health homes to increase efficiency of care coordination (e.g. CPAR/CII participation, establishment of referral processes), a triangulation of perspectives regarding the current state of care coordination in Palliser PCN health homes was made possible. **Annual Physician Survey Results:** • Survey questions are rated on a 5-point Likert Agreement scale and tallied using a weighted scoring method (95% return rate). When evaluating survey results, the PCN reviews non-nominal feedback when considering adjustments to initiatives/priorities/processes. Personal Experiences/Multi-disciplinary Team: "*During the past 12 months, I have been satisfied with the support the PCN staff in my office provides with patient transitions into/out of acute and/or specialty care (e.g. hospital discharge follow-ups)"* resulted in an average rating score of 82%.
Barriers	Please see discussion in Objective 2: Strong Partnerships & Transitions of Care for further details regarding Palliser PCN initiatives to advance this pillar.
4b	**Enhanced Access**

Summary and/or Achievements	Integration of PCN staff within 88% of health home teams is an enabler of enhanced access. The annual Palliser PCN physician survey contains a question related to satisfaction with PCN staff who support increased access to the health home.
Evaluation Activities	**Annual Physician Survey Results:** • Survey questions are rated on a 5-point Likert Agreement scale and tallied using a weighted scoring method (95% return rate). Personal Experience / Multi-disciplinary Team: "*I would recommend working with PCN employees to other physicians or NPs"* resulted in an average rating score of 91%. The annual Palliser PCN patient survey contains a question related to access: **Annual Patient Survey Results:** • Survey questions are rated on a 5-point Likert Agreement scale and tallied using a weighted scoring method (86% return rate). When evaluating survey results, the PCN reviews non-nominal feedback when considering adjustments to initiatives/priorities/processes. Access: "*During the past 12 months, I have found it easier to access care from my health home team in the way that I would like (e.g. in person, by phone, by video)"* resulted in an average rating score of 90%. Teams are regularly measuring Time to Third Next Available Appointment in order to support reporting of the mandated Schedule B Indicator. This includes **100% of PCN RNs/OHPs** measuring Time to Third Next Available Appointment. Physician and PCN RN/OHP access measures are reflected back to teams annually as part of the PCN RN/OHP performance assessment process. Teams which engage in access improvement, including those who participated in the Health Home Expedition (described throughout this document) are supported to measure supply, demand, activity, delay, panel size, no show rate, return visit rate and continuity to inform tests of change. Primary Care Network PALLISER **ACTIVITY AND CLINICAL MEASURES** Physician/Clinic: Lollipops and Rainbows Clinic; EMR System Used: ACME PCN Staff: Polly Palliser; PCN FTE: 0.8 Collection Period: 2025-01-01 to 2025-12-31; Months Collected: 12 Activity Statistics |	Physician	PCN Staff	Staff Target** | | Physician | PCN Staff | Staff Target** | |---|---|---|---|---|---|---|---| | Clinical Hours Worked | - | 1300 | 1343 | Access (TNA - # of days) | 5 S, 10 L | 2.0 | 3.0 | | Total Visits: all (≥18) | 5000 (4000) | 1500 | 1790 | No Show Rate | 4% | 2% | < 5% | | Unique Patients Seen*: all (≥18) | 3000 (2000) | 500 | 597 | Active EMR Panel: all (>=18) | 3500 (2500) | - | - | | Minutes per visit | - | 52 | 45 | Cross-panelled Rate (within PCN) | 10% | - | - | | Return Visit Rate | 1.7 | 3.0 | 3.0 | | | | | * The number of unique patients seen during the months for data collection. ** Targets based on evaluation and QI literature review. **Figure 34 – Example PCN Activity and Clinical Measures Sheet (portion with access measures)** PCN practice improvement facilitators support teams to plan, implement, and study QI tests based on their readiness for change in this domain (see Figure 59 – 5 A's of Health Home Optimization). Teams are supported to measure baseline access and set a specific, measurable, achievable, reliable, and time-bound (SMART) goal related to access. Teams are supported to visualize and interpret access measures to demonstrate progress and sustain motivation.
Barriers	No increase in overall PCN funding since 2012 has resulted in an in-clinic professional workforce cap that does not meet demand for population needs.
Schedule B Indicator	Third Next Available Appointment measurement maximized among PCN physicians. Additionally, *100% of PCN RNs/OHPs* measured Time to Third Next Available Appointment. This activity is supported by PCN Practice Improvement Facilitators, Educators, Supervisors and the Analyst. Please see pillar 4e below for a general discussion of Palliser PCN's process to align measurement for improvement with health homes' improvement activities.

THIRD NEXT AVAILABLE APPOINTMENT INDICATOR		FY 2025/26	FY 2024/25
Proportion of physicians measuring time to third next appointment	Numerator	90	90
	Denominator	90	90
	Proportion	100.0%	100.0%

Figure 35 – Third Next Available Appointment Indicator

4b.1	**To increase the proportion of residents with ready access to primary care**
Summary and/or Achievements	Referring back to Objective 2, numbered Initiative 1: The existing physician office (including after-hours service), ER and Health Link resources provide appropriate 24-hour management of access. Palliser PCN provides monthly updates to: • emergency departments • walk-in clinics • Stabilization & Transition Clinic • 25 different community resources (by email) • *Alberta Find A Provider* website administrators regarding family physicians and nurse practitioners currently accepting new patients. This information is also updated on the Palliser PCN website as shown below in the Evaluation Activities.
Evaluation Activities	Annual patient visits to “Need a Family Doctor or Nurse Practitioner? Click here.” link on PCN website homepage: **17,450**.  **Figure 36 - Website homepage with "Need a Family Doctor or Nurse Practitioner" link circled** Since 2015, the PCN has assisted public walk-in clinics to be listed on the PCN website, including hosting their walk-in schedule if they agree to keep it up-to-date. Annual patient visits to PCN Website walk-in pages: **10,100**.

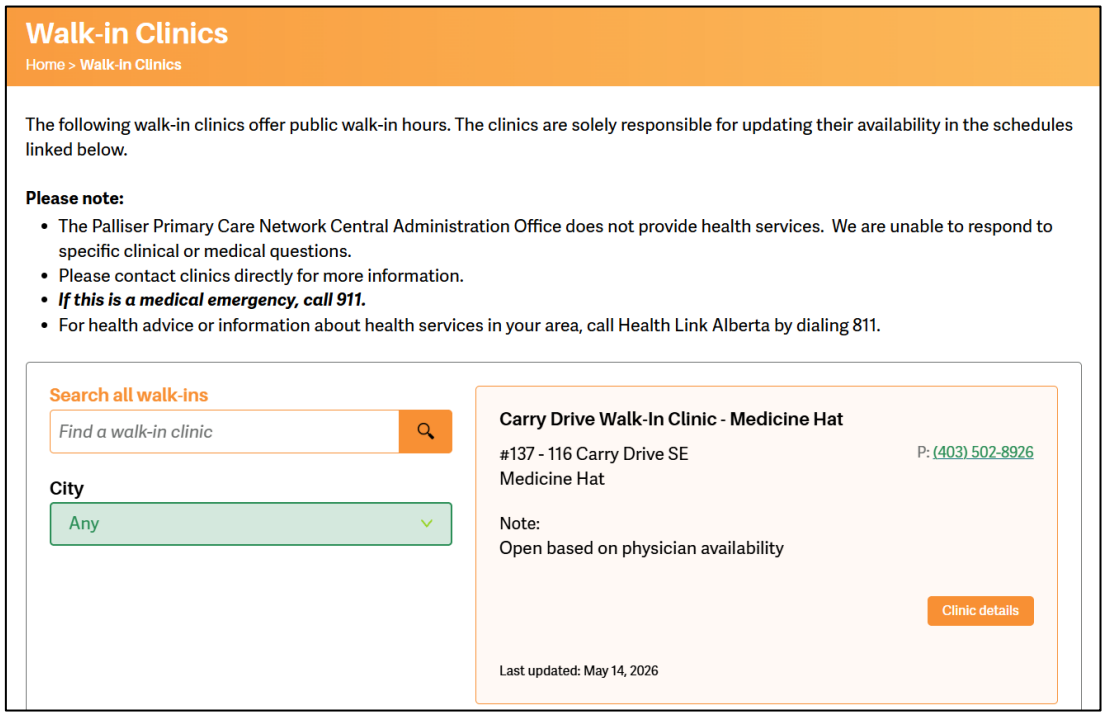


Figure 37 - PCN Website Walk-in Clinics landing page

There are 290 local community resources currently listed on the Palliser PCN website. Examples of listed resources include local caregiver support groups, newcomer supports, day programs and financial supports. Bidirectional communication between the PCN and community resources ensures website is up-to-date. The PCN also mass-contacts all listed resources each summer to ensure accuracy of posted information. Annual PCN website local resources section page visits (all pages): **112,800**.

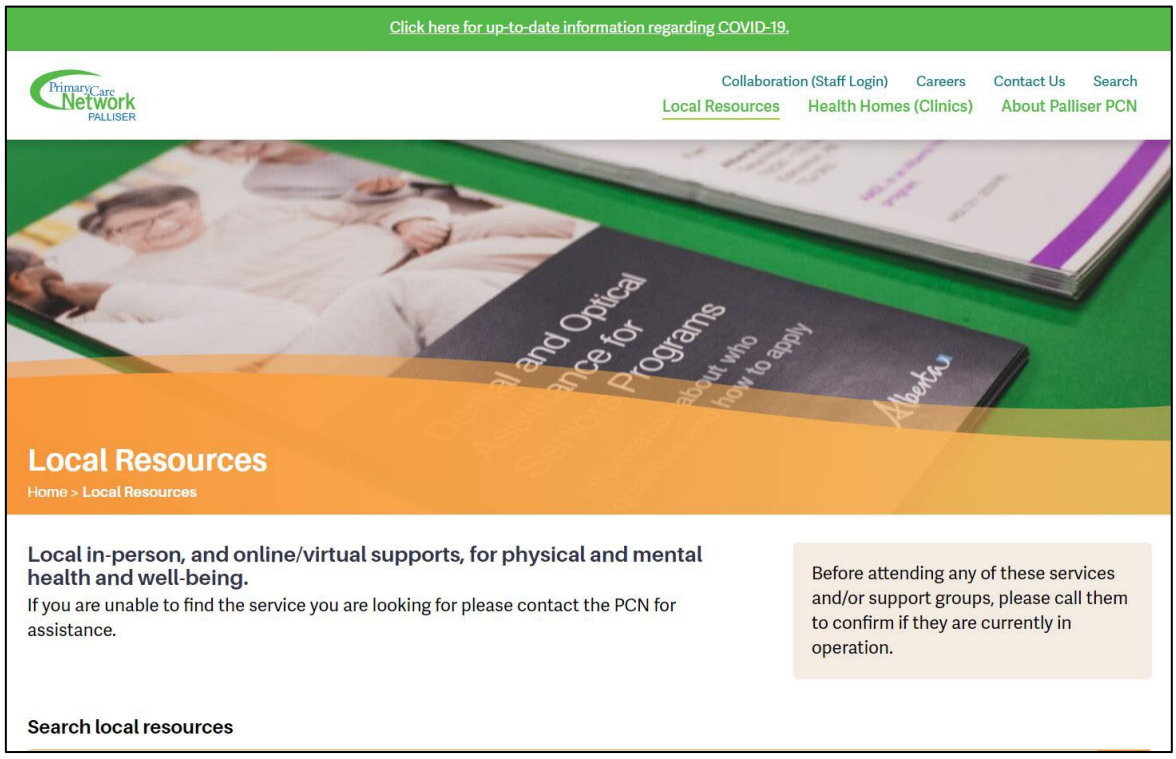


Figure 38 - PCN Website Local Resources landing page

Top 10 most accessed PCN Website Local Resources, 2025/26:

1. Alberta Seniors Benefit Program
2. Allowance for People Aged 60 to 64
3. Alcoholics Anonymous

	4. Children's Allied Health (Formerly CHADS) 5. Rainbow Medical Centre 6. Dr. Taylor – Dermatologist 7. Neat Feet Footcare 8. Alberta Precision Laboratories 9. Holy Family Parish & Organizations 10. Medicine Hat Recovery Centre
Barriers	• Provincial picture of unattached patients may be confusing local population where context is different • Public may not be able to differentiate between acute care and primary care access issues • There is no fulsome understanding of local population preferences for primary care access • Provider incentives may inadvertently be misaligned with enhanced access (e.g. medication dispensing fees)
Schedule B Indicator	The Patient Experience Indicator was defined in this section in the Annual Report template but in 4c in the Annual Report Guidelines. It is provided and discussed in Section 4c.
4b.2	**To provide coordinated 24-hour, 7-day-per-week management of access to appropriate primary care services**
Summary and/or Achievements	Please refer to Objective 2, numbered Initiative 1: The existing physician office (including after-hours service), ER and Health Link resources provide appropriate 24-hour management of access.
Evaluation Activities	Please refer to Objective 2, numbered Initiative 1: The existing physician office (including after-hours service), ER and Health Link resources provide appropriate 24-hour management of access.
Barriers	Please refer to Objective 2, numbered Initiative 1: The existing physician office (including after-hours service), ER and Health Link resources provide appropriate 24-hour management of access.

Schedule B Indicators	

PCN DASHBOARD INFORMATION (USE X TO INDICATE RESPONSE)

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

DISCUSSION

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

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

Please see discussion above re: programs vs. services.

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

Figure 39 - 2025/26 PCN Dashboard

4c	**Patient Centered Interactions**
Summary and/or Achievements	The existing Palliser PCN patient survey asks patients to review their experiences over the past 12 months. Average patient satisfaction in areas of patient experience has maintained above 91%.
Evaluation Activities	The Palliser PCN patient survey audience is patients with an interaction in the last year with a PCN RN/OHP. Highlights related to patient experience over the past 12 months:

PATIENT SURVEY RESULTS
Prepared January 2026
Return Rate: 86%

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Total Responses	PCN Average Satisfaction Score		
Weights	100%	75%	50%	25%	0%		**2025**	2024	2023
During the past 12 months:									
1. Overall, I have been satisfied with the care that I've received.	1179	176	13	32	3	1343	**94%**	97%	97%
2. My confidence to manage my health has improved through the support I receive from my PCN provider (e.g. RN, NP, BHC, Dietitian).	1048	279	35	30	2	1334	**92%**	93%	94%
5. I have felt that my PCN provider is knowledgeable regarding my health.	1155	195	13	32	3	1340	**94%**	96%	96%
8. Overall, I felt that receiving care from my health home team has improved my quality of life.	1021	286	41	32	3	1323	**91%**	94%	94%

Figure 40 – 2025 Patient Survey Results (patient experience)

Barriers	There is no fulsome understanding of local population preferences for input into local and system level interactions. Individualized patient centered interactions are difficult to measure.
Schedule B Indicators	The Schedule B Patient Experience Indicator could not be integrated into the existing Palliser PCN Patient Survey: • The mandated question, adjusted in April 2024 to query patient experience over the last 6 months, does not match the PCN's pre-existing 12-month lookback on its annual Patient Survey, maintained in its current form for long-term evaluation. • The mandated question is rated on a 6-point Likert Agreement scale, whereas the existing Palliser PCN Patient Survey uses a 5-point Likert Agreement scale. The most recent Schedule B Patient Experience Indicator Toolkit, including the April 2024 adjustment, did not indicate that PCNs could deviate from the 6-point Likert scale. The PCN has maintained the 5-point Likert Agreement scale on its existing annual Patient Survey for long-term evaluation. During the reporting period, Palliser PCN supported developing and administering an independent Clinic Patient Survey containing a small number of questions, customized to match the areas the clinic was working on if indicated by survey results, universally beginning with the Schedule B Patient Experience Indicator question, as seen in the below example:

[Clinic Logo]

Primary Care Network PALLISER your health. your team.

CLINIC PATIENT SURVEY

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

Please check the option which most accurately reflects your opinion.

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

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

Figure 41 - Example Clinic Patient Survey with mandated Patient Experience Indicator (Q1)

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

PATIENT EXPERIENCE INDICATOR		FY 2025/26	FY 2024/25
Patients who rated the care they received as "Excellent" or "Very Good"	Numerator	82	122
	Denominator	84	123
	Proportion	97.6%	99.2%

Figure 42 - Patient Experience Indicator

Five PCN health homes were approached and two chose to utilize this survey during the reporting period. The process included:

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

Both teams chose to proceed with survey administration Option 1; one team additionally used Option 2 for a provider who was not present on the day surveys were conducted by the administrative staff member. Option 1 minimized burden to health home staff and maximized return rate compared to Options 2 and 3. In-clinic surveying required 8 hours of administrative time from Central Office administrative staff, surveying a total of 71 patients, meaning 9 patients were surveyed per hour of administrative staff time. This was a noted increase compared to the previous reporting period administrative burden of 5 patients surveyed per hour using Option 1.

The PCN continues to note that individual participating clinics are limited in engagement to incorporate clinic patient surveys into team effectiveness QI work. Two teams that were approached to consider a clinic patient survey chose instead to complete a team effectiveness survey: this may have been more aligned with their current Health Home Optimization QI priorities in the team-based care domain, to measure and discuss internal team communication, trust, leadership and culture), possibly as a precursor to including the patient perspective.

4d	Organized Evidence Based Care
Summary and/or Achievements	All PCN workshops (please see Section 1, Priority Initiative: Measurement and Practice Improvement for workshop listing) are aligned with evidence based care from the planning stage to the follow-up. These workshops support the PCN objective of ensuring health home teams are able to practice using up-to-date evidence based information. With a goal to maximize evidence based quality improvement activities, in January 2024, 10 health home teams (18 physicians and 34 clinic team members) embarked on the Health Home Expedition – an approximately 18-month collaborative learning series delivered by quality improvement faculty with experience with Alberta AIM and other longitudinal team-based collaborative QI initiatives. This involved a customized approach to the local context, including the PCN's priority focus on Access and Team-based care. This series completed during the reporting period, with the last in-person learning session occurring in June 2025.



Figure 43 – Palliser PCN Health Home Expedition Overview

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

Team effectiveness elements were incorporated throughout the Expedition and included activities that explore team behaviours, attitudes, personality types and communication styles. These team effectiveness activities involved team discussion, individual reflection and group action planning over the Expedition period.

Expected outcomes from this collaborative learning series included:

- increased team QI competency – among participating teams and the PCN administrative team; and
- increased Health Home Optimization (HHO) scores among health home teams

For participating team QI competency: there was 87% participant agreement with the post-Expedition survey question regarding whether the Expedition enhanced the team member's knowledge, understanding and confidence in applying QI methods.

Related to HHO scores: 90% of participating health homes had an increased score in at least one HHO domain, with 70% improving in at least one of the PCN's priority focus domains of Access and Team-based care.

Finally, related to administrative team QI competency: in addition to the increase in a further 58% of non-participating health homes also had an increased score in at least one Health Home Optimization domain. This suggests PCN facilitators had the ability to apply some learnings from the Expedition to support non-participating teams. It was noted that only 25% of these teams increased in Access and/or Team-based care, indicating the Expedition had a positive effect on supporting improvements in the PCN's priority focus domains.

During the reporting period, Palliser PCN offered to teams to administer the mandated Primary Care Team Dynamics Survey (Song et al., 2015). Participating teams were assisted to review results of the team effectiveness survey and supported to identify/test possible team improvements such as:

- Huddles: dedicated weekly huddle (e.g. 10 minutes) helped team members with their work that day/week
- Meetings: regular times for team to meet to discuss items like clinic administration decisions, quality improvement, etc.

In addition to the 5 teams that completed the team effectiveness survey, 16 health home teams pursued other team-based care projects without using the survey. A few teams collected information from their members via brainstorming tools (e.g. comment boxes, writing on papers in break rooms) so they could fix the problems their members raised. The majority of the 16 teams are measuring how they coordinate team-work around hospital discharges, referral rejections, goals of care designations and specific patient populations (e.g. cancer, CHF).

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

	Mode of Access				*Total FY 2024/25*	*Total FY 2023/24*
Month-Year	iOS	Web	Android	**Total**		
Apr 2024	25	326	22	**373**	*561*	*290*
May 2024	19	356	20	**395**	*519*	*313*
Jun 2024	46	388	12	**446**	*390*	*198*
Jul 2024	20	319	19	**358**	*386*	*202*
Aug 2024	11	359	6	**376**	*335*	*269*
Sep 2024	11	265	8	**284**	*427*	*127*
Oct 2024	17	324	1	**342**	*596*	*155*
Nov 2024	16	266	1	**283**	*351*	*211*
Dec 2024	18	219	14	**251**	*275*	*403*
Jan 2025	11	252	6	**269**	*430*	*562*
Feb 2025	21	258	4	**283**	*394*	*395*
Mar 2025	20	288	12	**320**	*354*	*471*
Total	**235**	**3,620**	**125**	**3,980**	*5,018*	*3,596*

Figure 44 - DynaMed usage by month and mode, with comparison to previous two FY usage

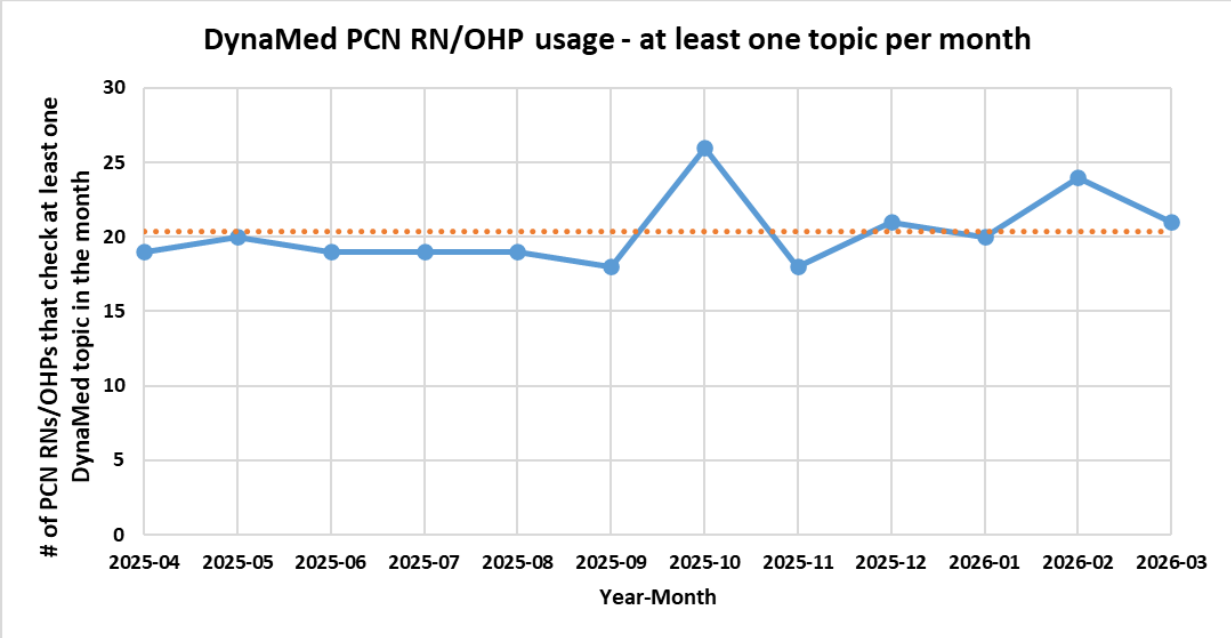


Figure 45 - DynaMed Monthly Usage by PCN RNs/OHPs

Topic Title	Topic Views
Vitamin B12 Deficiency	271
Semaglutide	158
Telmisartan/hydrochlorothiazide	65
Immunizations in Children and Adolescents	44
Amlodipine	38
Estradiol	36
Irbesartan	35
Gabapentin	32
Menopause	32
Pregabalin	31
Tramadol hydrochloride/Acetaminophen	25
Amlodipine	24
Perindopril Erbumine	24
Tirzepatide	24
Candesartan Cilexetil	23
Escitalopram Oxalate	22
Atorvastatin Calcium	21
Ezetimibe	21
Ramipril	21
Empagliflozin	20
Metformin hydrochloride	20
Perindopril	18
Duloxetine hydrochloride	17
Indapamide	17
Diverticulitis	16

Figure 46 - Top 25 DynaMed topics and total views, April 2025 to March 2026

Evaluation Activities	During the reporting period, the PCN applied for and acquired Canada Health Infoway grants for AI scribe licenses for 25 PCN RNs that were interested in trialing this new tool in their visits.
	• Summer 2025: Initial Rollout
	  ○ PCN administrative team contacted eligible PCN RNs and physicians to solicit interest and obtain permission
	  ○ PCN facilitators worked with each health home to:
	  ▪ develop processes for obtaining and documenting patient consent for using AI scribe
	  ▪ update their PIA to include use of an AI scribe
	  ▪ complete AI scribe vendor training and simulate 10 visits
	  ○ PCN supervisors checked in with each AI scribe user to review initial experiences with consent processes and using AI scribe
	• September-December 2025: evaluated early integration of AI scribes into clinical processes
	  ○ AI scribe usage per regular clinical hour (using PCN timesheet for hours)

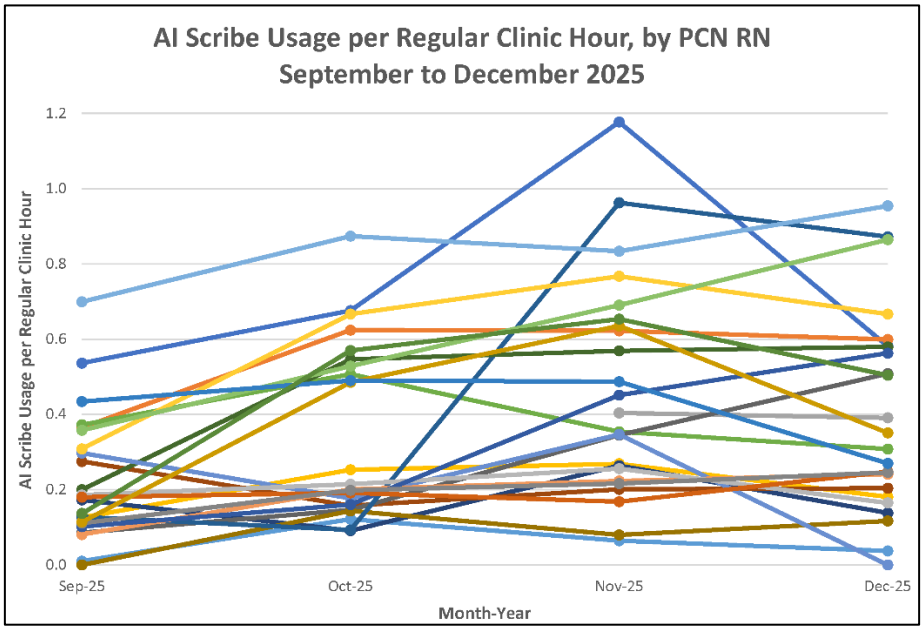


Figure 47 – PCN RN AI Scribe Usage per Regular Clinic Hour, by Month

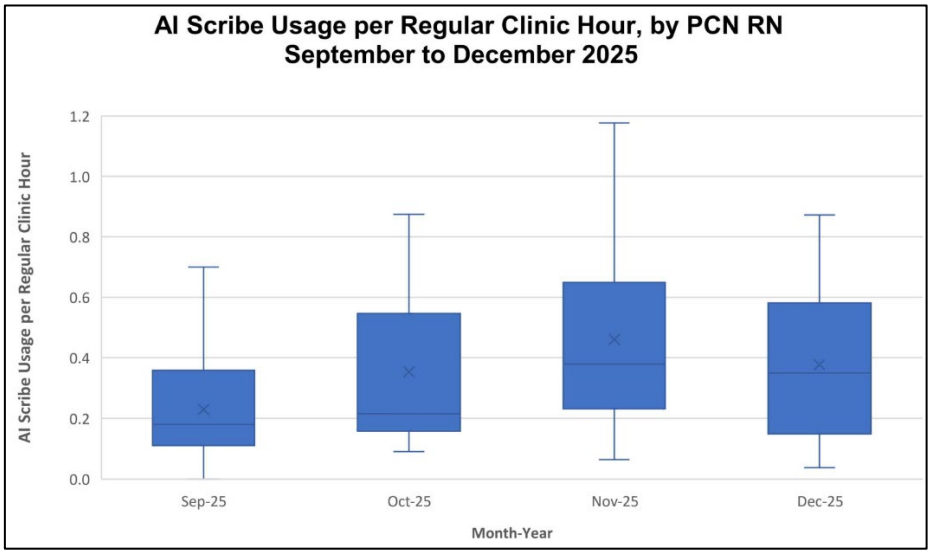


Figure 48 – Ranges of PCN RN AI Scribe Usage per Hour, by Month (x = mean)

Figure 47 shows the significant individual RN variation during the initial four months of use: PCN RNs used the AI scribe anywhere from zero to nine times per fulltime (7.5 hour) day (equivalent to 1.2 scribe sessions per hour), with a median usage in December 2025 of approximately 3 AI scribe sessions per fulltime day (equivalent to 0.35 scribe sessions per hour). Figure 48 shows few changes in overall staff AI scribe usage per hour during this period: October and November increases and a lower December level may reflect increased use due to novelty to be replaced with a lower stable state.

- Utilization (minutes per visit) for AI scribe adopters: changes from baseline and changes over initial use period

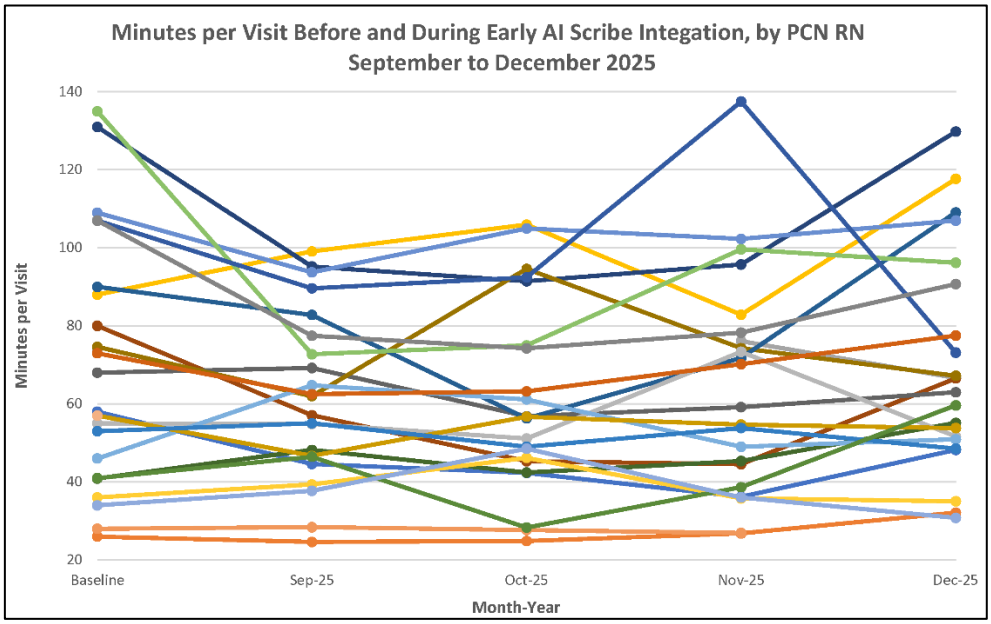


Figure 49 – PCN RN minutes per visit, before and during initial AI scribe use

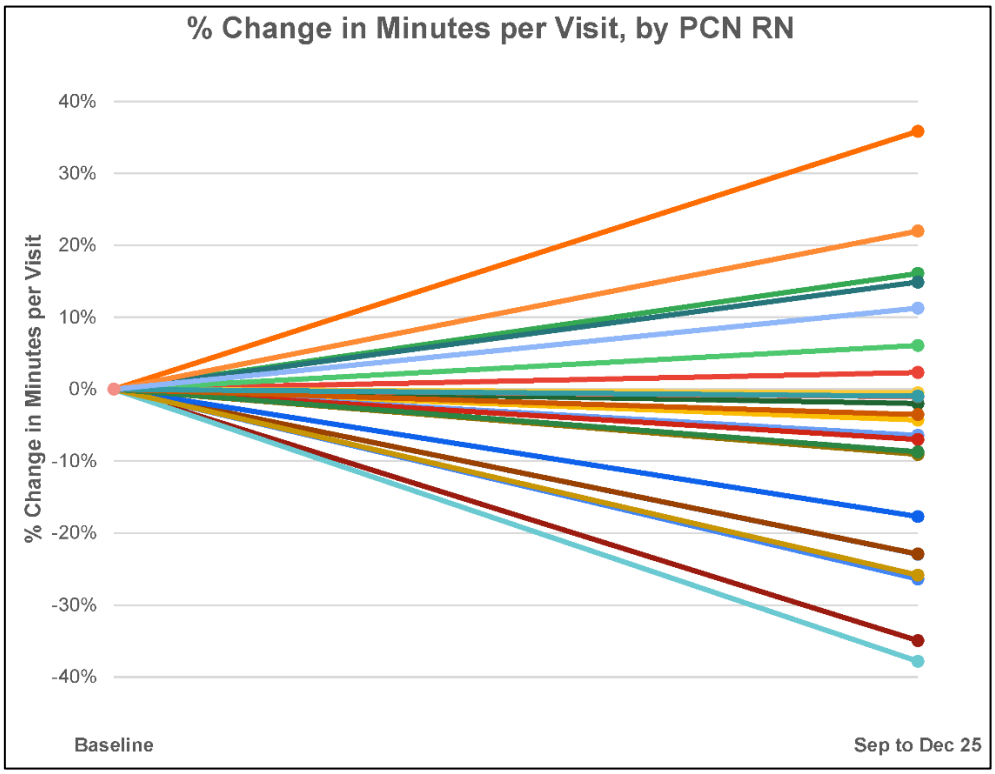


Figure 50 – Ranges of RN minutes per visit, before and during overall initial use

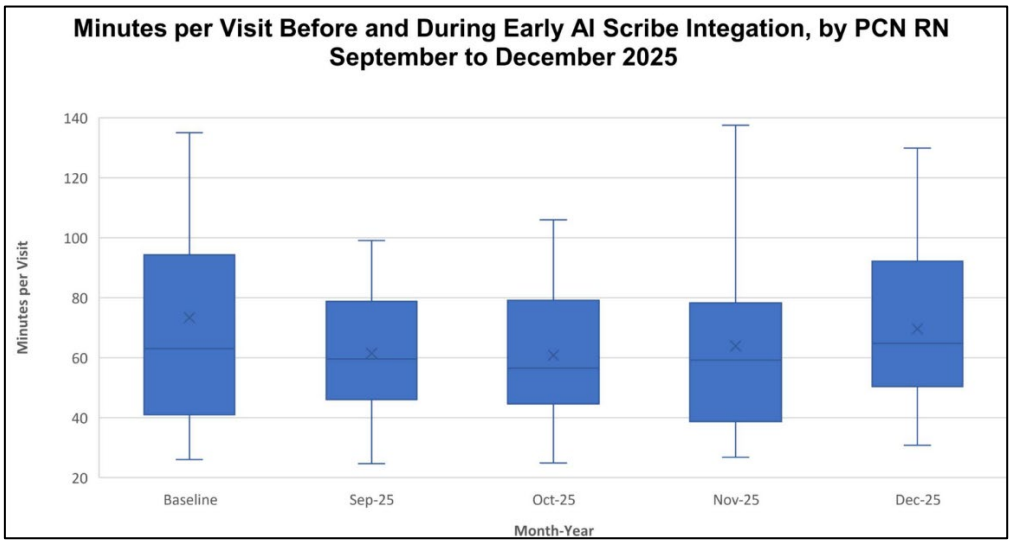


Figure 51 – Ranges of PCN RN minutes per visit, before/during initial use (x = mean)

Figure 49 demonstrates the variation in baseline utilization (measured in minutes per visit) as well as the variation in utilization throughout the early integration period. Figure 50 shows the wide variety of utilization increases and decreases for RNs. Reduced utilization (i.e. fewer visits per fulltime day) for some may reflect the RN requiring more time to review and correct AI scribe output than to complete manual charting without the AI scribe. Increased utilization for others may reflect the RN optimizing their workflow and saving time compared to manual charting. 17 RNs increased in their overall utilization by an average of 14% (from 79 to 68 minutes per visit) during the initial period and 8 RNs decreased by an average of 30% (from 64 to 83 minutes per visit). Figure 51, however, shows that the distribution of minutes per visit decreased during the first two months of use and subsequently trended back up. This may indicate that initial time savings, though evident at the beginning, were offset after initial PCN supervisor check-ins during which expectations of chart accuracy and quality were reiterated.

- Comparison of monthly AI scribe usage to total visits: to contextualize any changes in September to December 2025 utilization with the frequency RNs are using AI scribes in their visits

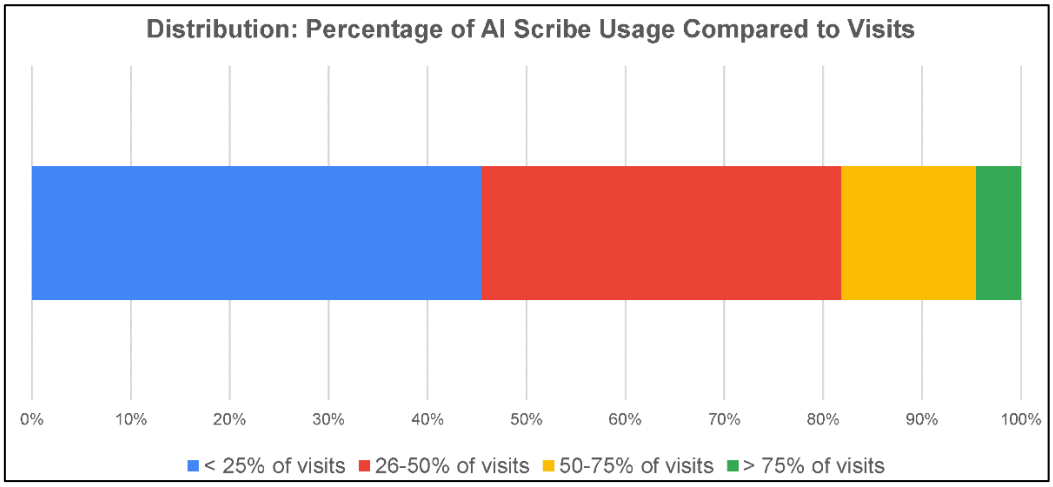


Figure 52 – Distribution of ranges: % of visits for which PCN RNs used an AI scribe

Most (>80%) RNs are using AI scribes for fewer than 50% of visits, with almost half using them for fewer than 25% of visits, measured by comparing monthly AI scribe sessions to monthly visits charted in the EMR. This may indicate RNs have found utility among only specific types of visits; for some RNs, this may change depending on evolution of AI scribe products and increasing RN familiarity.

- March 2026: chart note assessments – evaluated changes from baseline (non-AI scribe usage) in seven dimensions of chart note accuracy and quality

Accuracy
The medical note contains information that is true and free from errors or hallucinations.
Comprehensiveness
The medical note includes complete documentation of all relevant patient information, including medical history, examination findings, diagnostic results, and treatment plans without omissions.
Care Plan
The medical note provides a holistic understanding of the patient's health status. The medical note allows health care professionals to readily interpret the patient's health status and develop a plan of care.
Organization
The medical note is well-structured, adhering to the SOAP (Subjective, Objective, Assessment, and Plan) format.
Comprehension
The medical note is accessible and devoid of ambiguity or difficult-to-understand terms, phrases, or sections. The medical note allows health care professionals to readily interpret the patient's clinical status and make informed decisions.
Conciseness
The medical note succinctly and effectively conveys all essential information, avoiding unnecessary elaboration or redundancy.
Usefulness
The medical note presents pertinent clinical information in a clear, concise, and actionable manner, facilitating effective communication, decision-making, and continuity of care among health care professionals involved in the patient's care.

Figure 53 – Dimensions of chart note accuracy and quality used for evaluation[8]

A chart note audit of PCN RNs implementing AI scribes was conducted by a PCN administrative team member with significant clinical and supervisory experience. Each chart note was evaluated in 7 dimensions (see Figure 53), with each dimension rated on a 3-point Likert scale (Excellent, Good, Poor).

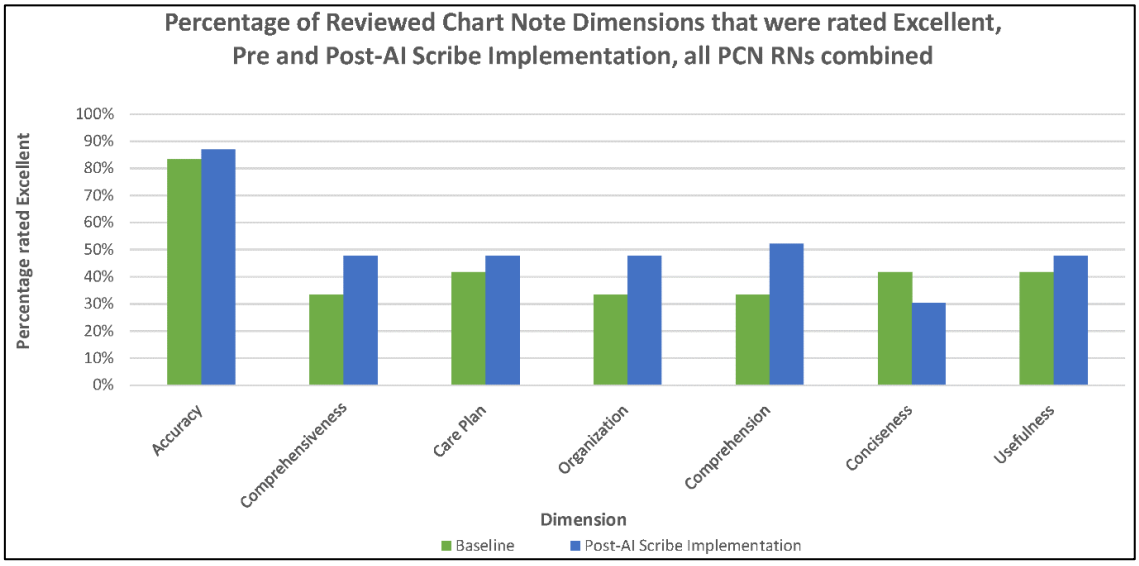


Figure 54 – Chart Note Reviews: Percentage of Chart Note Excellent Ratings

Compared to baseline, reviewed chart notes had more Excellent ratings – with the exception of the Conciseness dimension. As this chart note review occurred 3-6 months after the initial supervisor check-in, it may reflect RN work to customize and regularly review AI scribe outputs.

Annual Employee Survey Results:

The annual Palliser PCN employee survey contains a question related to satisfaction with education.

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

[8] Ha E, Choon-Kon-Yune I, Murray L, Luan S, Montague E, Bhattacharyya O, Agarwal P. Evaluating the Usability, Technical Performance, and Accuracy of Artificial Intelligence Scribes for Primary Care: Competitive Analysis. JMIR Hum Factors. 2025 Jul 23;12:e71434, tab. 1. doi: 10.2196/71434. PMID: 40700466; PMCID: PMC12309782.

	PCN Management and Administration: "*During the past 12 months, I have been satisfied with the amount and type of support and education that I receive from the PCN."* resulted in an average rating score of 90%.
Barriers	• Health home desire • Increasing evidence-based resources can cause health provider confusion • When evidence-based resource guidelines are not aligned, there may be risk for errors
Schedule B Indicators	Schedule B Screening Indicator results for the reporting period are summarized below:

SCREENING INDICATOR		FY 2025/26	FY 2024/25
Offers of screening maneuvers completed	Numerator	246,168	244245
	Denominator	394,329	395567
	Proportion	62.4%	61.7%

Figure 55 - Screening Indicator

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

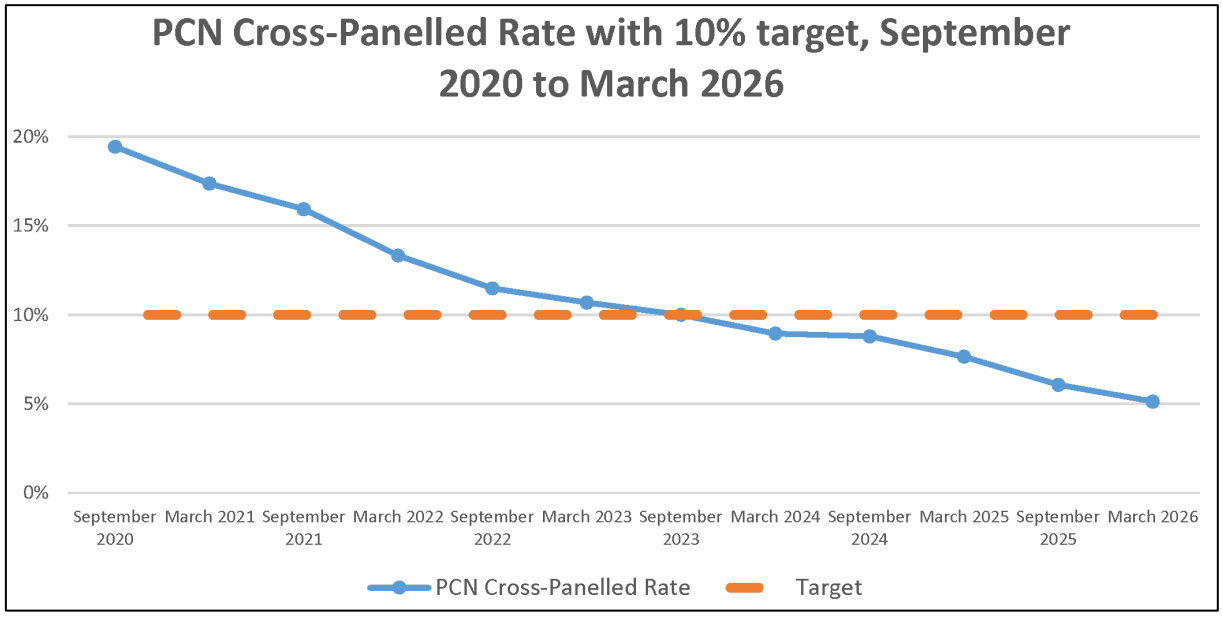
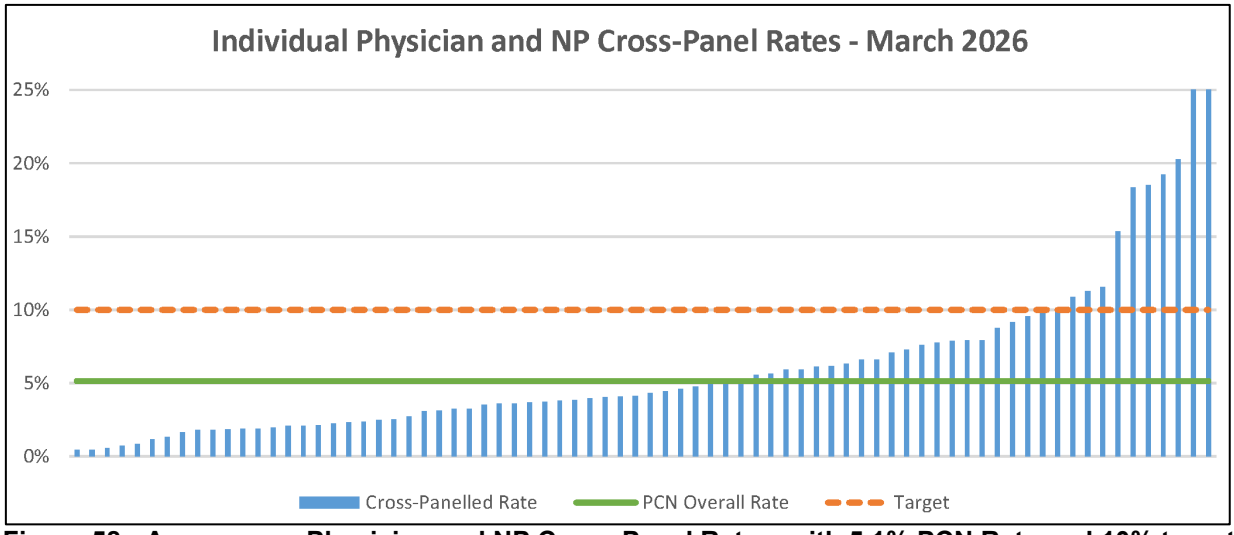
It could be suggested that the increase in proportion of screening maneuvers completed during the reporting period is partially due to changes in patient care modes (e.g. decrease in virtual care and increase in in-person care) and screening contexts post pandemic (e.g. increase in scheduled lab appointments,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

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

The Schedule B Team Effectiveness Indicator location was not defined in the Annual Report Guidelines or Annual Report template, but is provided below:

TEAM EFFECTIVENESS PROGRESS INDICATORS		FY 2025/26	FY 2024/25
Proportion of member physician clinics in PCN that conducted team effectiveness survey during the year	Numerator	5	3
	Denominator	40	40
	Proportion	12.5%	7.5%
Proportion of clinics that conducted a team effectiveness survey during the year. (PCN Clinics and Physician Member Clinics)	Numerator	5	3
	Denominator	40	40
	Proportion	12.5%	7.5%

Figure 56 - Team Effectiveness Indicators

4e	Panel and Continuity
Summary and/or Achievements	In the reporting period, the PCN supported physicians who were interested in maintaining/increasing their active EMR family practice panel and minimizing cross-panelled patients to achieve their desired level of PCN staffing support. This included supporting teams to review their panels, contact patients, administratively inactivate patients, understand their CPSA obligations to see panelled patients and assist physicians to enroll in CPAR/CII. Where interested, physicians were also assisted to measure and interpret their access, compare to the current panel size and define an ideal panel size. At a PCN level, the cross-panelled rate is 5.1%, down from 7.7% in the last reporting period. Individual PCN physician and NP cross-panelled rates vary as seen below, with rates as low as 0.4% and as high as 28%. 96% of individual physician and NP cross-panelled rates are below 20% (up from 90% in the last reporting period), with 84% (previously 68%) already under the PCN target of 10% and 57% (previously 39%) under the PCN's stretch goal of 5% cross-panelled.  **Figure 57 - Overall PCN Cross-Panelled Rate over time**  **Figure 58 - Anonymous Physician and NP Cross-Panel Rates, with 5.1% PCN Rate and 10% target**

Evaluation Activities	Palliser PCN uses its Adapted 5 A's for Health Home Optimization Model to engage health home teams to optimize in many areas, including panel and continuity. PCN Practice Improvement Facilitators support teams to assess their current state, leveraging their EMR, and consider/test process improvements, ensuring standardized panel processes can be shared within the team (e.g. documented in clinic handbooks) to minimize variation and enable successful cross-coverage.

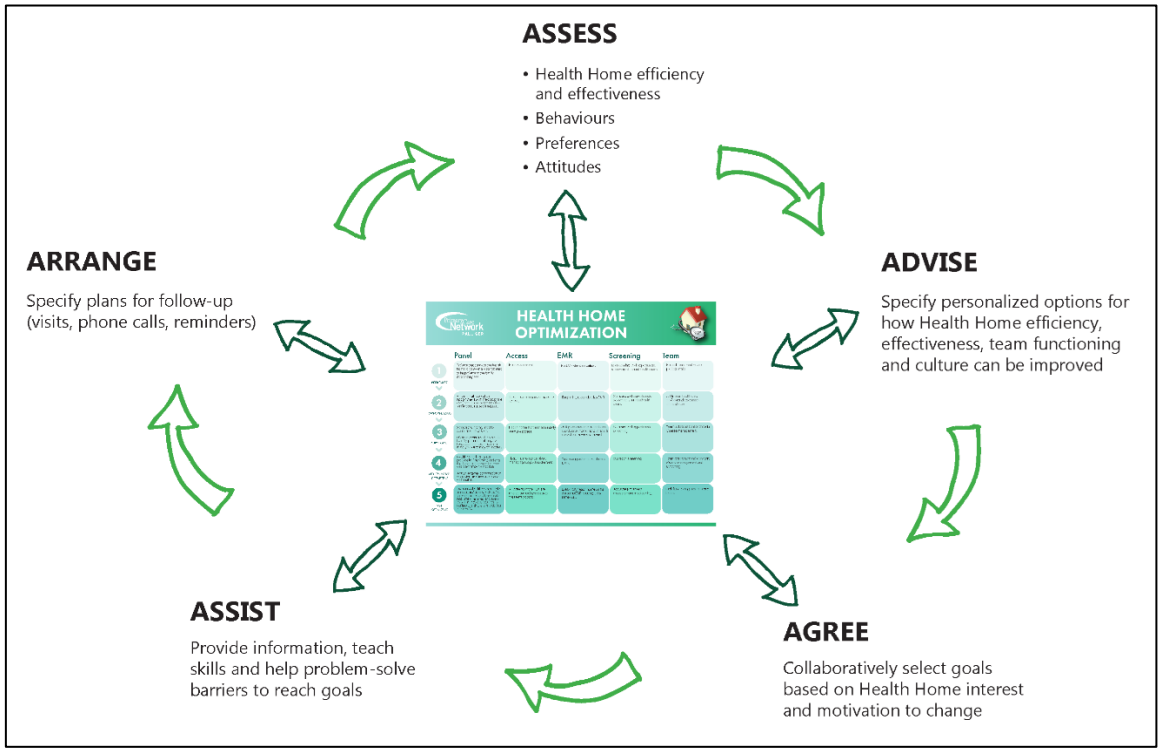


Figure 59 - Palliser PCN's Adapted 5 A's for Health Home Optimization Model

In the current iteration of its Activity and Clinical Measures sheet, the PCN has integrated the physician and NP cross-panelled rate (seen below in Figure 60 in the Activity Statistics section) to support conversation about panel validation, CPAR/CII enrollment and a population health approach to panel management.

ACTIVITY AND CLINICAL MEASURES

Clinic	Lollipops and Rainbows Clinic		EMR System Used	ACME
PCN Staff	Polly Palliser		PCN FTE	0.8
Collection Period	2025-01-01	to 2025-12-31	Months Collected	12

Activity Statistics

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

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

** Targets based on evaluation and QI literature review.

Figure 60 - Sample PCN Activity and Clinical Measures Sheet – Cross-panelled rate circled

A cross-panelled patient is one with more than one PCN family physician or nurse practitioner who identifies the patient to be on their active EMR family practice panel. This could be due to a patient switching health homes without notifying the former health home, a patient actively receiving primary

health care from multiple health homes, or a record-keeping issue where a patient has received specialty care from one clinic that erroneously identified the patient to be on the family practice panel.

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

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

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

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

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

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

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

- PCN level: The PCN utilizes its average physician continuity measure (77% in 2026 PCN Proxy Panel Report) to support a comparison with individual physician continuity when health homes engage in continuity quality improvement conversations and are interested in a baseline average for their local physician peers. When this occurs, a stratification of individual patients by continuity range (<50%, 50-80%, >80%) is often found to be a useful metric for comparison. The PCN's 2026 stratification by continuity range (data up to March 31, 2025):

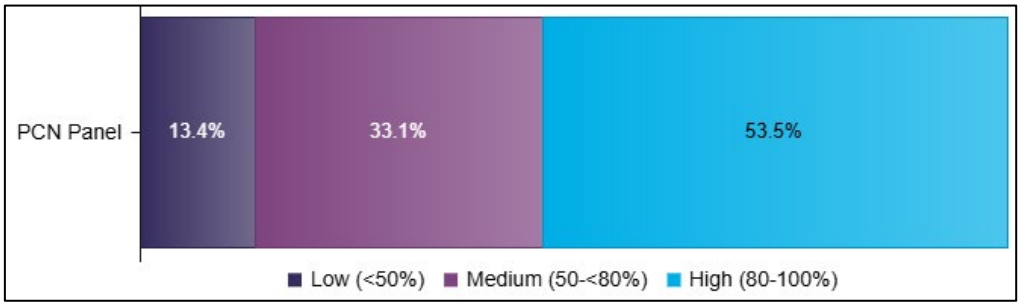


Figure 61 - 2026 HQA Report Patient Continuity, by range of individual patient continuity

Using the 2026 HQA patient continuity rates and Palliser PCN's March 2026 physician profile data, there are approximately 12,100 PCN patients with low continuity with their family physician or nurse practitioner. When the PCN looks at its cross-panel rate of 5.1% and measures 2,600 cross-panelled PCN patients (down 35% from 4,000 patients in March 2025 and down 69% from 8,300 patients in March 2021), it is possible to conclude that while some patients may have low continuity with their family physician due to visiting multiple health homes, potentially 4 times as many patients may be seeking primary health care elsewhere due to other factors, such as delay to see family doctor or nurse practitioner, hours of operation, specialty procedures (e.g. pap by a different physician or nurse practitioner, cosmetic procedures).

- Health home level: Although physicians and nurse-practitioners in a multi-provider clinic are supported by the PCN to measure their internal continuity (percentage of the time patients are seeing their only family physician versus a colleague physician in the same clinic) using their EMR-sourced data, HQA reports are necessary to measure external continuity.[9] Similar to the discussion at the PCN level, health home teams that are interested in maximizing continuity often

drill into stratification of continuity by ranges in order to quantify and identify (with a Confirmed Panel Report) the number of patients with lowest continuity. These teams are supported to develop processes including flagging charts and contacting patients with the lowest continuity (<50%) to ensure that the health home is aware of its patients' primary health care encounters with other physicians/NPs and to identify barriers to patients seeking this care from their health home.

A significant activity related to panel management is the PCN's use of its Activity and Clinical Measures Sheet to support focused clinical quality improvement prioritization and evaluation. With a primary focus on *measurement for improvement*, clinical data is extracted from health home EMRs and presented in an Activity and Clinical Measures Sheet to members of health home teams, typically to PCN RNs/OHPs and PCN physicians. These sheets frequently become the starting point for clinical practice improvement work.

Activity and clinical measures are taken both at:

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

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

The below Figures display the current Palliser PCN Activity and Clinical Measures (ACM) sheet and the PCN-defined Screening Indicators defined on the reverse side of the Measures sheet. Although this is used at an individual physician or NP and RN/OHP level, the data shown in the below Figures shows the PCN's aggregate data for all physician, NP and PCN RN/OHP encounters measured during the reporting period:

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

ACTIVITY AND CLINICAL MEASURES

Clinic	All of Palliser PCN			**EMR System Used**	Various
PCN Staff	All PCN Staff			**PCN FTE (est., normalized from regular clinic hours worked)**	41.7
Collection Period	2025-01-01	to	2025-12-31	**Months Collected**	12

Activity Statistics

	Physician or NP	PCN Staff	Staff Target**		Physician or NP	PCN Staff	Staff Target**
Clinical Hours Worked	-	65,419	74,695	**Access (TNA - # of days)**	0-94 S, 2-119 L	0-56	3.0
Total Visits: all (≥18)	258,067 (228,318)	65,880	99,593	**No Show Rate**	3%	4%	< 5%
Unique Patients Seen*: all (≥18)	75,304 (58,878)	25,399	33,198	**Active EMR Panel: all (>=18)**	105,438 (85,227)	-	-
Minutes per visit	-	60	45	**Cross-panelled Rate (within PCN)**	5%	-	-
Return Visit Rate	3.4	2.6	3.0				

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

** Targets based on evaluation and QI literature review.

Clinical Indicators (≥18)

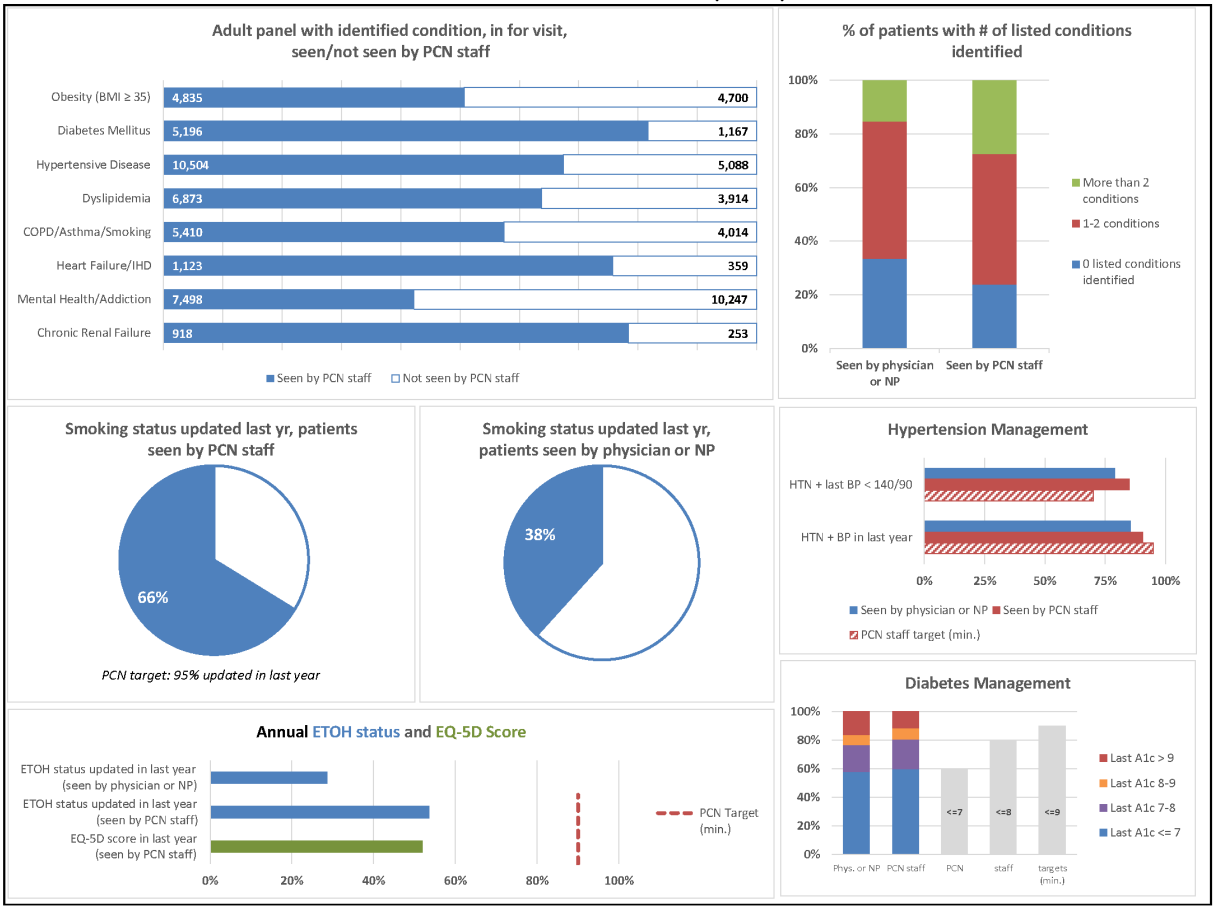


Figure 62 – 2025 PCN Activity and Measures Sheet (PCN physician, NP and RN/OHP EMR data)

Screening and Prevention Indicators (2026)

Clinic	**All of Palliser PCN**	**EMR System Used**	Various
PCN Staff	**All PCN Staff**	**PCN FTE**	41.7
Collection Period	2025-01-01 to 2025-12-31	**Months Collected**	12

			Screening rates			
Indicator	**Eligible**	**Detail**	**Patients seen by physician or NP**	**Patients seen by PCN staff**	**PCN Average - EMR (2025)**	**PCN Average - HQA (2025)**
Diabetes Screening	All > 40	A1c or Fasting Glucose Every 3 years	91%	96%	91%	(delayed)[1]
Cholesterol Screening	All 40-74	Every 5 years	92%	96%	92%	(delayed)[1]
Colorectal Screening	All 50-74	Colonoscopy every 10 years or FIT every 2 years	66%	69%	63%	65%[1]
Mammography	F 45-74	Every 2 years	65%	73%	68%	74%
Bone Mineral Density	M > 65	Once	36%	42%	36%	(not measured by HQA)[2]
Bone Mineral Density	F > 65	Once	70%	76%	70%	(not measured by HQA)[2]
Pap	F 25-69	Every 3 years	49%	55%	52%	70%
Blood Pressure	All > 18	Annually	74%	78%	73%	(not measured by HQA)[2]
Weight	All > 18	Every 3 years	87%	86%	84%	(not measured by HQA)[2]
Height	All > 18	Every 3 years	84%	71%	80%	(not measured by HQA)[2]
Diabetes Management	Diabetics	A1c every 3 months when targets not being met and every 6 months when targets being met	70%	77%	66%	(not measured by HQA)[2]
Influenza Immunization	All > 6 mths	Annually	5%	13%	9%	26%

[1]HQA issues in 2025 with measuring diabetes, cholesterol, colorectal cancer screening rates (Connect Care transition)

[2]Not typically measured by HQA

> 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 63 – 2025 PCN Screening Indicator Annual Results on PCN ACM sheet

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

- Number of patients seen by PCN RNs/OHPs with chronic conditions identified as a proportion of those seen by PCN physician or NP in the last year (*Figure 64: a subsection of Figure 62*)
- Average PCN RN/OHP utilization and access measures (*Figures 65 and 67*)
- PCN RN/OHP and physician or NP no show rates *(Figure 68)*

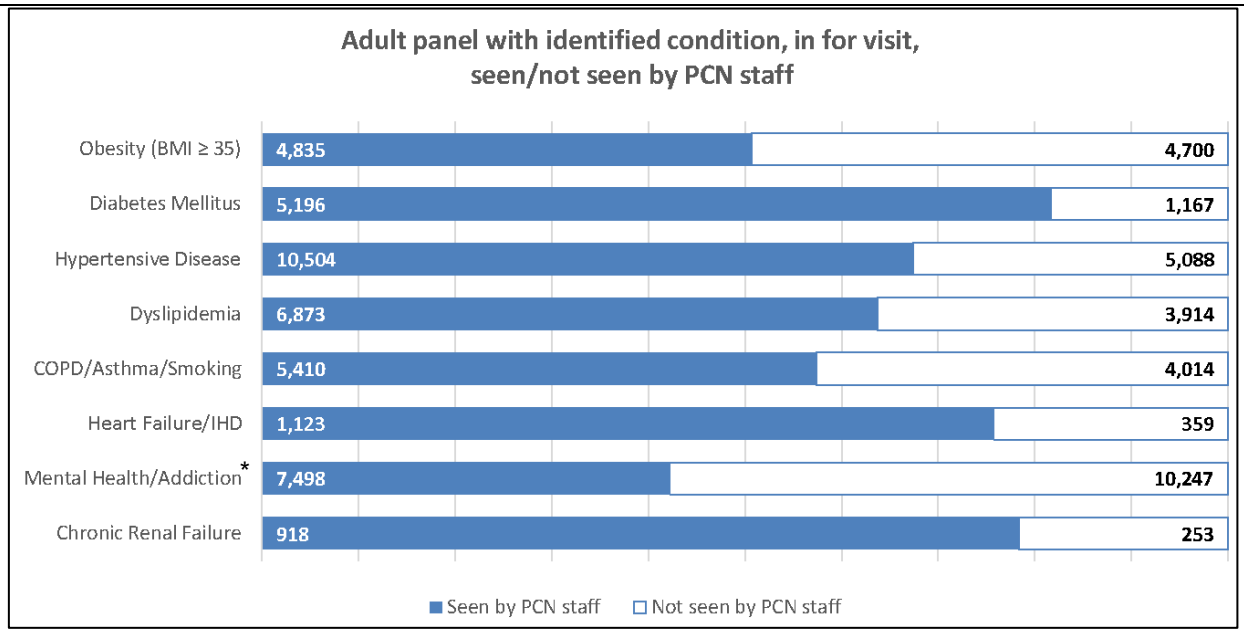


Figure 64 - Patients seen by PCN OHP vs. seen only by physician or NP, per condition grouping

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

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

Total unique patients seen by PCN RNs/OHPs	25,399
Total patient visits with PCN RNs/OHPs	65,880
Average number of patients seen by PCN RNs/OHPs per 1.0 FTE	609
Average minutes per patient	60
Average annual return visit rate	2.6

Figure 65 - Aggregate and average PCN RN/OHP utilization measures

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

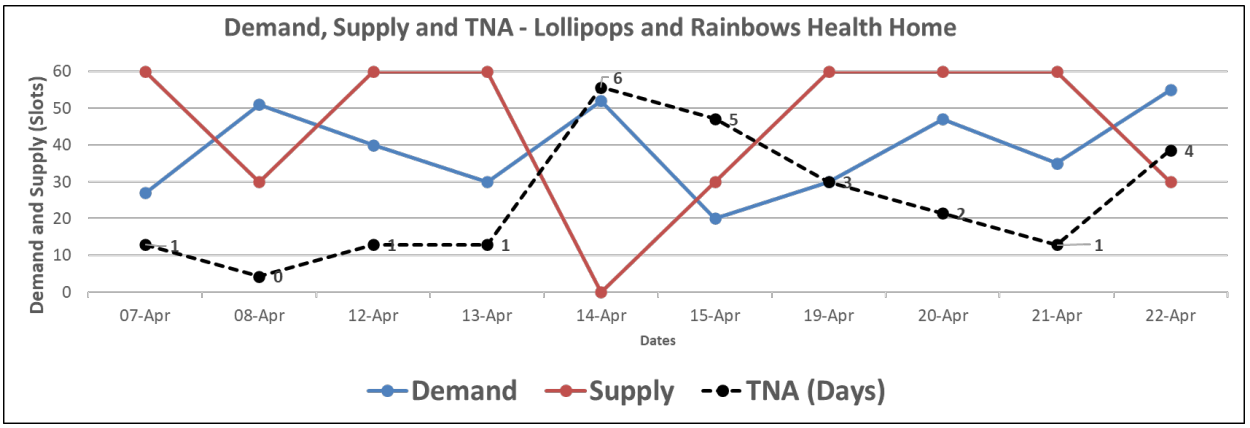


Figure 66 - Example visualization of Time to Third Next Available used in quality improvement

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

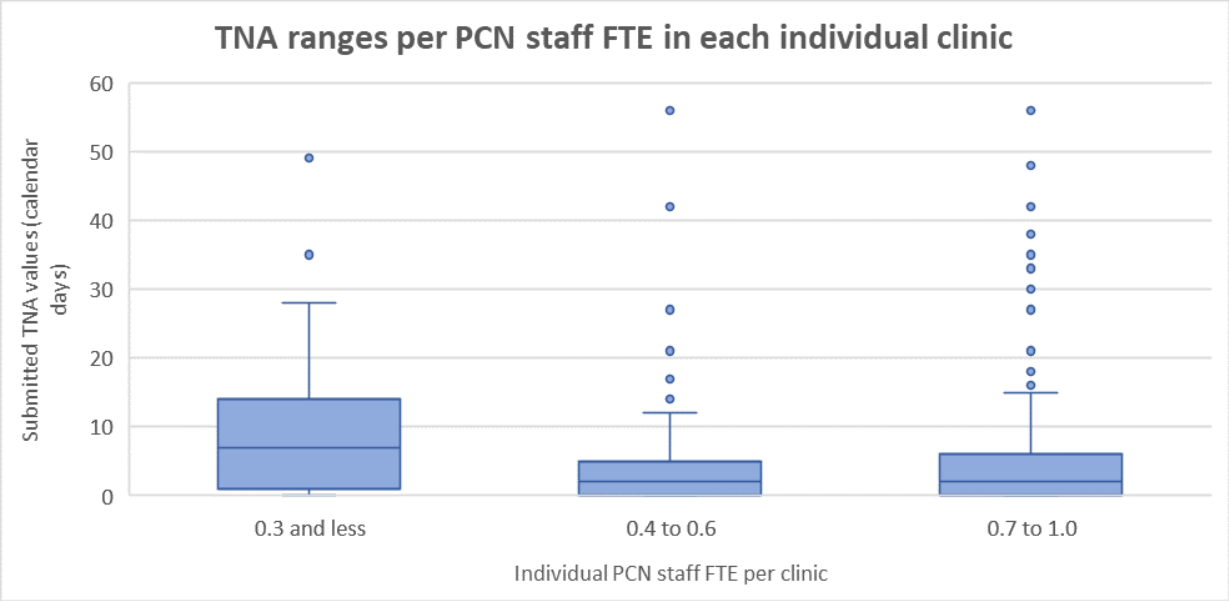


Figure 67 - Ranges of individual submitted TNA values for PCN RNs/OHPs, per staff-clinic FTE

Although there are many limitations including the relatively small number of PCN staff in each FTE range, as well as the lack of high quality published evidence to support measurement of aggregate TNA, the above data supports the informal observation that PCN RN/OHP access is more likely to be optimized (low TNA) with a mid-to-high clinic FTE compared to a low FTE (0.3 and less), as patients can be referred to the RN/OHP during a larger proportion of the week.

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

Average no show rate, physicians or NPs	3.1%
Average no show rate, PCN BHCs	9.5%
Average no show rate, PCN non-BHCs	3.6%

Figure 68 - Average no show rates per provider type

The average PCN BHC no show rate, remains higher than other provider groups and has grown in the last reporting period (8.7% in 2024/25). Overall, no show rates appear stable for physicians compared to the previous reporting period (3.4% in 2024/25), and has reduced for non-BHC PCN RHPs, compared to the previous reporting period (4.7% in 2024/25). This could be due to increased success of no-show reduction strategies (e.g. appointment confirmations via patient portals) and support from PCN facilitators.

Variation between measures for patients seen by RNs/OHPs and physicians could highlight potential improvement opportunities. The PCN Education and Clinical Supervisors, along with PCN Practice Improvement Facilitators, seek to identify high performing teams who have a high success rate in chronic disease screening and management so that, where possible, other teams might learn from successful processes, workflows, EMR optimizations, etc.

As seen in Figure 63, the PCN integrates HQA PCN Proxy Panel screening indicators in the ACM sheet it provides to individual physicians and PCN RNs/OHPs. Unfortunately, HQA screening information is limited when compared to the PCN's EMR data; accuracy of some HQA data has been reduced for several years due to the PCN's understanding of HQA issues with accessing Connect Care lab data. Highly engaged health homes also use their own HQA proxy panel and confirmed panel reports as an additional, confirmatory data source to support review of screening indicators and evaluate patient utilization outside the health home, e.g. hospital admissions and ED utilization.

Barriers	Increased interest in HQA physician and NP panel reports resultant from physicians' PCPCM and NPs' Nurse Practitioner Primary Care Program participation may provide an enhanced opportunity to increase data literacy among family practice providers and teams as they consider accelerating the use of population data to inform quality improvement prioritization. Increased recognition of the potential utility of HQA panel reports may increase Health Home Optimization in the areas of Panel and Access as measured by the PCN. An increased understanding of the limitations of HQA some data elements (described in above Evaluation Activities section) may increase engagement with health home data in general. Some teams may alternatively disengage further with data, including the PCN's EMR-sourced data, if limitations of HQA data are believed to apply to all health data, including PCN-developed ACM sheets.
Schedule B Indicators	None defined; discussion of the PCN's use of HQA reports, however, occurs in several locations in the Evaluation Activities above.
4f	**Engaged Leadership**
Summary and/or Achievements	Please see discussion in Objective 1: Accountable & Effective Governance above.
Evaluation Activities	Please see discussion in Objective 1: Accountable & Effective Governance above.
Barriers	Please see discussion in Objective 1: Accountable & Effective Governance above.
Schedule B Indicators	Indicator reporting and discussion occurs in Objective 1.
4g	**CII/CPAR**

How many participating physicians or participating providers are registered to your PCN?	90
Percentage of participating physicians or participating providers using a CII-CPAR compatible EMR?	94%
Percentage of participating physicians or participating providers routinely verify their panel?	94%
Percentage of participating physicians or participating providers have been included on a confirmation of participation (CoP) for CPAR submission?	94%
Percentage of participating physicians or participating providers have been listed as custodians on a clinic Privacy Impact Assessment (PIA) that has been assessed for CII/CPAR participation as being either current or requiring only minor revisions?	94%
Percentage of participating physicians or participating providers are routinely submitting verified panel information to CII/CPAR?	80%

2.3. Primary Health Care Indicator Set – Reporting:

Alberta

PPHS WILL NOT ACCEPT ANNUAL REPORTS IF ALL FIELDS ARE NOT COMPLETED

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

#	THIRD NEXT AVAILABLE APPOINTMENT INDICATOR		FY 2025/26	FY 2024/25
1	Proportion of physicians measuring time to third next appointment	Numerator	90	90
		Denominator	90	90
		Proportion	100.0%	100.0%
#	**PATIENT EXPERIENCE INDICATOR**		**FY 2025/26**	**FY 2024/25**
2	Patients who rated the care they received as "Excellent" or "Very Good"	Numerator	82	122
		Denominator	84	123
		Proportion	97.6%	99.2%
#	**SCREENING INDICATOR**		**FY 2025/26**	**FY 2024/25**
3	Offers of screening maneuvers completed	Numerator	246,168	244245
		Denominator	394,329	395567
		Proportion	62.4%	61.7%
#	**GOVERNANCE INDICATOR**		**FY 2025/26**	**FY 2024/25**
4	Did the PCN Non-Profit Corporation Board / Joint Governance Committee complete **both** the following activities during the year? 1) Collective self-assessment of the PCN Non-Profit Corporation Board / Joint Governance Committee as a whole. 2) Performance improvement plan for the PCN Non-Profit Corporation Board / Joint Governance Committee.		**YES**	**YES**
4.1	Did the Board use Health Standards Organization's Governance Functioning Tool in their self-assessment process?		**YES**	**YES**
4.2	If not, what self-assessment tool was used?		**N/A**	
4.3	Did the Board receive approval from PPHS for the use of this alternative tool?			
#	**LEADERSHIP INDICATOR**		**FY 2025/26**	**FY 2024/25**
5	Was a performance assessment completed during the year for the PCN Administrative Lead and all other staff members directly reporting to the PCN Non-Profit Corporation Board/Joint Governance Committee?		**YES**	**YES**
#	**TEAM EFFECTIVENESS PROGRESS INDICATORS**		**FY 2025/26**	**FY 2024/25**
6	Proportion of member physician clinics in PCN that conducted team effectiveness survey during the year	Numerator	5	3
		Denominator	40	40
		Proportion	12.5%	7.5%
6.1	Proportion of clinics that conducted a team effectiveness survey during the year. (PCN Clinics and Physician Member Clinics)	Numerator	5	3
		Denominator	40	40
		Proportion	12.5%	7.5%
#	**PCN REPORT ON PATIENT'S MEDICAL HOME READINESS (CII/CPAR)**		**FY 2025/26**	**FY 2024/25**
7.0	**How many Participating Physicians or Participating Providers are registered to your PCN (Number of active participating physicians/providers that are members of your PCN as of the last day of the fiscal reporting year.-** (This indicator will serve as a denominator for subsequent indicators.)		90	90
7.1	**What percentage of Participating Physicians or Participating Providers are are using a CII-CPAR compatible EMR?** (Numerator: Aggregate number of participating physicians/providers who are using one of the CII/CPAR compatible Electronic Medical Record (EMR) as of the last day of fiscal year.)	Numerator	85	85
		Denominator	90	90
		Proportion	94.4%	94.4%
7.2	**What percentage of Participating Physicians or Participating Providers verify their panel on a yearly basis?** (Numerator Count of participating physicians and participating providers that are routinely verifying their panels.)	Numerator	85	85
		Denominator	90	90
		Proportion	94.4%	94.4%
7.3	**What percentage of Participating Physicians or Participating Providers have been included on a Confirmation of Participation (CoP) for CPAR submission?** (Numerator Count of participating physicians and participating providers that have been listed on a CoP for CPAR sent to PPHS as of the last day of the fiscal reporting year.)	Numerator	85	85
		Denominator	90	90
		Proportion	94.4%	94.4%
7.4	**What percentage of Participating Physicians or Participating Providers have been listed as custodians on a clinic Privacy Impact Assessment (PIA) that has been assessed for CII/CPAR participation as being either current, or requiring only minor revisions?** (Numerator Participating physicians and participating providers that are listed as custodians on a clinic PIA that has received a favourable assessment from the eHealth Services Support Team as of the last day of the fiscal reporting year)	Numerator	85	85
		Denominator	90	90
		Proportion	94.4%	94.4%
7.5	**What percentage of Participating Physicians or Participating Providers are routinely submitting verified panel information to CII CPAR?** (Numerator Count of participating physicians and participating providers sending monthly panel data to CPAR at least one time in the fiscal year)	Numerator	72	73
		Denominator	90	90
		Proportion	80.0%	81.1%

Figure 69 – Schedule B Indicator Report

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

PALLISER PRIMARY CARE NETWORK

FINANCIAL STATEMENTS

March 31, 2026

Palliser PCN

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

March 31, 2026

version 1.0

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

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

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

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

Palliser PCN
Statement of Operations
For the Year Ended March 31, 2026

	Notes	2026 Budget (Unaudited)	2026 Actual (Audited)	2025 Actual (Audited)
Revenue				
Per Capita Funding - Operating		6,487,866	6,501,107	6,119,619
Per Capita Funding - Capital		-	-	-
Interest and Investment Income		68,000	49,955	102,822
Fee For Service		-	-	-
PCN Nurse Practitioner Support Program (NPSP) Funding		116,000	84,666	88,915
Shared Services (Specify in Notes)		-	-	-
AH-AMA Agreement PCN Investment		-	-	478,421
Operational Stability Fund		330,000	-	-
Total Revenue		**7,001,866**	**6,635,728**	**6,789,777**
Expenses (Priority Initiatives)				
Professional Support Within Health Homes		5,271,866	5,060,218	5,084,495
Measurement & Practice Improvement		548,000	472,143	609,506
		-	-	-
		-	-	-
		-	-	-
		-	-	-
		-	-	-
		-	-	-
PCN NPSP		116,000	84,666	88,915
Zonal Expenses (Specify in Details tab)		-	-	-
Priority Initiative Subtotal		**5,935,866**	**5,617,027**	**5,782,916**
Expenses (Central Allocations)				
Evaluation		-	-	-
PCN Administrative Lead Salary		161,000	186,439	168,425
PCN Administrative Lead Benefits		34,000	39,372	35,568
Other Management Salaries (Specify in Details tab)		318,000	301,566	290,090
Other Management Benefits (Specify in Details tab)		34,000	34,657	31,946
Administration (Specify in Details tab)		519,000	456,667	480,832
Information Technology		-	-	-
Support Services (Specify in Details tab)		-	-	-
Amortization		-	-	-
(Gain)/Loss on disposal of Capital Asset(s)		-	-	-
Central Allocations Subtotal		**1,066,000**	**1,018,701**	**1,006,861**
Total Expenses		**7,001,866**	**6,635,728**	**6,789,777**
Excess/(Deficiency) of Revenue Over Expenses		**$ -**	**$ -**	**$ -**

Palliser PCN
Statement of Financial Position (Audited)
As at March 31, 2026

		2026 Actual	2025 Actual
Assets			
Current Assets:	Notes		
Cash		$ 1,647,410	$ 1,802,457
Short-term investments		-	-
Accounts receivable		35,501	44,901
Prepaid expenses		63,702	49,702
Other assets		-	-
Total Current Assets		**1,746,613**	**1,897,060**
Capital Assets (Net Amortization) *[Schedule 2]*		-	-
Total Assets		**$ 1,746,613**	**$ 1,897,060**
Liabilities and Net Assets			
Current Liabilities:			
Accounts payable and accrued liabilities	Note 4	774,535	739,600
Due to Alberta Health Services		-	-
		774,535	739,600
Non-Current Liabilities:			
Unexpended deferred revenue - PPHS	Note 5	208,873	391,538
Outstanding BPA Expenses (list in notes)	Note 5	391,538	385,212
Unexpended deferred revenue - Other	Note 5	-	-
Unexpended NPSP funding	Note 5	21,667	30,710
Unamortized capital contributions	Note 6	-	-
Operational Stability Fund	Note 8	350,000	350,000
Other liabilities		-	-
Total Liabilities		**1,746,613**	**1,897,060**
Net Assets:			
Net Assets *[SCNA]*		-	-
Closing Balance - Net Assets		**-**	**-**
Total Liabilities and Net Assets		**$ 1,746,613**	**$ 1,897,060**
		-	-

Palliser PCN
Statement of Cash Flows (Audited)
For the Year Ended March 31, 2026

	2026 Actual	2025 Actual
Operating Activities:		
Excess/(Deficiency) of Revenue Over Expenses	$ -	$ -
Non-cash transactions		
Amortization	-	-
(Gain)/Loss on disposal of capital asset(s)	-	-
Amortization of deferred capital contributions	-	-
Change in non-cash working capital:		
(Increase)/Decrease in accounts receivable	9,400	(18,138)
(Increase)/Decrease in prepaid expenses	(14,000)	(28,000)
(Increase)/Decrease in other assets	-	-
Increase/(Decrease) in accounts payable and accrued liabilities	34,935	32,613
Increase/(Decrease) in amount due to Alberta Health Services	-	-
Increase/(Decrease) in Unexpended deferred revenue - PPHS	(182,665)	5,613
Increase/(Decrease) in Unexpended deferred revenue - Other	-	-
Increase/(Decrease) in Outstanding BPA Expenses	6,326	116,885
Increase/(Decrease) in Unexpended NPSP funding	(9,043)	30,710
Increase/(Decrease) in Operational Stability Fund	-	20,000
Increase/(Decrease) in other liabilities	-	-
Cash generated from/(used by) operations	(155,047)	159,683
Investing Activities:		
Purchase of Capital Assets	-	-
Proceeds on Disposal of Capital Assets	-	-
Cash generated from/(used by) investing activities	-	-
Financing Activities:		
Capital Contributions received	-	-
Proceeds from long term debt	-	-
Principle payments on long-term debt	-	-
Cash generated from financing activities	-	-
Increase/(Decrease) in cash and investments	(155,047)	159,683
Cash and investments at the beginning of the year	1,802,457	1,642,774
Cash and investments at the end of the year	**$ 1,647,410**	**$ 1,802,457**

Palliser PCN
NOTES TO FINANCIAL STATEMENTS
For the year ended March 31, 2026

1. AUTHORITY, PURPOSE AND OPERATIONS

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

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

The PCN's primary activity is to operate programs in south-eastern Alberta that will:
- Improve care of patients with chronic/complex care needs.
- Increase patient access to primary care.
- Facilitate greater use of multidisciplinary teams and improve coordination and integration with other health care services.

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

2. SIGNIFICANT ACCOUNTING POLICIES AND REPORTING PRACTICES

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

a) Revenue Recognition

These financial statements use the deferral method of accounting for contributions, key elements of which are:
- Restricted operating contributions are deferred and recognized as revenue in the year in which the related expenses are incurred.
- Restricted capital contributions are deferred and recognized as revenue in the year the related amortization of the capital asset is recorded.
- Investment income is recognized as restricted contributions.

b) Financial Instruments and Risks

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

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

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

c) Measurement of Financial Instruments

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

d) Cash and cash equivalents

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

e) Short-Term Investments

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

f) Capital Assets

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

g) Line of Credit Facility

At March 31, 2026, the PCN had a line of credit available in the amount of $500,000 with interest at the bank's prime lending rate plus 1.75% per annum. The effective interest rate at year end is 6.20%.
The line of credit is secured by a general security agreement on the assets of the PCN. At March 31, 2026, there is no amount outstanding on this credit facility (2025 - $nil).

h) Use of Estimates and Assumptions

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

3. RELATED PARTY TRANSACTIONS

Program operating costs include:

 Funds provided to Physicians for supervision of health professionals and program planning, rental of premises for health professionals and clinic supports, and education/training are disclosed in Schedule 1. There was $nil outstanding to Physicians at year end (2025 - $nil).

 Funds provided to Alberta Health Services to reimburse the payroll cost of the PCN Executive Director are disclosed in the Statement of Operations. There was $nil outstanding to Alberta Health Services at year end (2025 - $20,000).

4. BUDGET

The budget for 2026 was approved by the Board in March 2025.

5. UNEXPENDED DEFERRED REVENUE

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

Changes in unexpended deferred revenue are as follows:

	2026						2025
	PPHS	BPA	NPSP	OSF	Other entities	Total	Total
Balance at the beginning of year	391,538	385,212	30,710	350,000	-	1,157,460	984,252
NPSP repayment during the year			(30,710)			(30,710)	-
Received or receivable during the year, net of repayments	6,502,653		106,333		-	6,608,986	6,985,658
Transfer from Balance at the beginning of the year to approved BPAs	(391,538)	391,538			-	-	-
Restricted investment income & other income	49,955				-	49,955	102,822
Recognized as revenue - operating	(6,501,107)	(177,885)	(84,666)	-	-	(6,763,658)	(6,812,450)
Recognized as revenue - Interest	(49,955)		-			(49,955)	(102,822)
Transfer to purchase of Capital Assets	-	-			-	-	-
Transferred to UDR from expired BPAs	207,327	(207,327)			-	-	-
Transfer to OSF	-			-		-	
Balance at the end of year	208,873	391,538	21,667	350,000	-	972,078	1,157,460

BPA Calculations

BPA Taxonomy	BPAs Brought Forward From Previous Period with Approved Extension	New BPAs Approved	BPA Funds Spent During 2025-2026	Balance	Is the BPA expired as of March 31, 2026?	Expired BPA Funds	Outstanding BPA Funds
PPCN 2024-25 BPA 01	385,212	-	177,885	207,327	Yes	207,327	
PPCN 2025-26 BPA 01	-	391,538	-	391,538	No		391,538
	-	-	-	-			
Total BPA Funds as of March 31, 2026	385,212	391,538	177,885	598,865		207,327	391,538

6. UNAMORTIZED CAPITAL CONTRIBUTIONS

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

	2026			2025
	PPHS	Other entities	Total	Total
Balance at the beginning of year	-	-	-	-
Transferred from unexpended deferred revenue	-	-	-	-
Gains / (Losses) on Disposal of capital assets	-	-	-	-
Proceeds from disposal of capital assets	-	-	-	-
Less amounts recognized as revenue	-	-	-	-
Balance at the end of year	-	-	-	-

7. PER CAPITA REVENUE

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

Calculation of Per capita	Enrollees		Rate	Amount
Eligible per capita payments				
April 2025	104,643	$	31	3,243,933
October 2025	105,120	$	31	3,258,720
Total eligible per capita payments for 2025/2026				**6,502,653**

8. OPERATIONAL STABILITY FUND

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

OSF Calculations			
Balance at the beginning of the year	$	350,000	**A**
OSF Funds spent in 2025/2026	$	-	**B**
Balance at the end of the year	$	350,000	**C = A-B**
Maximum eligible OSF	$	350,000	**D**
Allowable amount PCN Allocation	$	-	**E = D-C**
PCN Allocation to OSF	$	-	**F (This value should not exceed E)**

9. PCN NURSE PRACTITIONER SUPPORT PROGRAM (NPSP) FUNDING

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

10. COMMITMENTS AND CONTINGENCIES

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

11. ECONOMIC DEPENDENT

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

12. APPROVAL OF FINANCIAL STATEMENTS

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

Palliser PCN
Schedule 1 - Expenses by Object
For the Year Ended March 31, 2026

	2026		2025
	Budget (Unaudited)	Actual (Audited)	Actual (Audited)
Physicians: Clinical (Specify in Details tab)	-	-	-
Physicians: in lieu of FFS	-	-	-
Physicians: Administrative (Specify in Details tab)	243,000	193,648	213,165
Physicians: Other (Specify in Details tab)	230,000	183,559	231,484
Physicians Subtotal	**473,000**	**377,207**	**444,649**
Alberta Health Services - Purchased Services	-	-	-
Alberta Health Services - Office Space	-	-	-
Alberta Health Services - Other (Specify in Details tab)	-	-	-
Non-Physician Direct Care Providers	4,735,866	4,607,992	4,631,476
Zonal Expenses	-	-	-
Other Expenses (Specify in Details tab)	1,793,000	1,650,529	1,713,652
Amortization	-	-	-
Total Expenses	**$ 7,001,866**	**$ 6,635,728**	**$ 6,789,777**

Palliser PCN
Schedule 2: Schedule of Capital Assets (Audited)
For the Year Ended March 31, 2026

Cost

	Lease Improvements	Other Capital Assets	Total
Balance April 1, 2025	97,080	-	97,080
Additions	-	-	-
Disposals	-	-	-
Cost at March 31, 2026	**$ 97,080**	**$ -**	**$ 97,080**

	Lease Improvements	Other Capital Assets	Total
Balance April 1, 2025	97,080	-	97,080
Amortization for the period[1]	-	-	-
Amortization on disposals	-	-	-
Accumulated Amortization at March 31, 2026	**$ 97,080**	**$ -**	**$ 97,080**
Net Book Value March 31, 2026	**$ -**	**$ -**	**$ -**
Net Book Value March 31, 2025	**$ -**	**$ -**	**$ -**

Palliser PCN
Nurse Practitioner Support Program Analysis Working Paper (Unaudited)
For the Year Ended March 31, 2026

Quarters	PPHS Approved FTE(s)	NPSP Funding from PPHS	PCN Recorded FTE(s)	PCN Recorded NPSP Spend	Note Req'd?
April 1, 2025 - June 30, 2025	0.00	$ -	0.60	$ 20,903	Yes
July 1, 2025 - September 30, 2025	0.00	$ -	0.60	$ 23,287	Yes
October 1, 2025 - December 31, 2025	0.00	$ -	0.60	$ 21,706	Yes
January 1, 2026 - March 31, 2026	0.93	$ 135,333	0.60	$ 18,770	Yes
Prior year adjustment (Oct to Dec 2024)		$ (29,000)			
Total		**$ 106,333**		**$ 84,666**	
Difference between PPHS and PCN NPSP		$ 21,667			

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

NOTES

Total NP Expenses	$ 84,666

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

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

Palliser PCN
Staffing Summary (Unaudited)

	Budget as at March 31, 2026	Actual as at March 31, 2026	Actual as at March 31, 2025
Participating Clinics	40	40	40
Participating Physicians	97	90	90
Participating Nurse Practitioners (NPPCP)	0	4	4
Enrollees	104,643	105,647	104,643

	Budget FTE as at Mar.31, 2026	Budget Cost ($) Apr.1, 2025 to Mar.31, 2026	Budget Head Count at Mar.31, 2026	Actual FTE as at Mar.31, 2026	Actual Cost ($) Apr.1, 2025 to Mar.31, 2026	Actual Head Count at Mar.31, 2026	Actual FTE as at Mar.31, 2025	Actual Cost ($) Apr.1, 2024 to Mar.31, 2025	Actual Head Count at Mar.31, 2025
Direct Care Provider (DCP)									
Nurse Practitioner	0.80	116,000	1	0.60	84,666	1	0.61	88,915	1
Registered Nurse	36.90	3,723,116	53	35.70	3,658,226	51	39.09	3,909,561	52
Licenced Practical Nurse									
Social Worker									
Dietitian									
Pharmacist									
Physiotherapist									
Occupational Therapist									
Mental Health Therapist									
Behavior Health Consultant	8.50	896,750	13	8.20	865,100	13	6.00	633,000	7
Cardiac Rehab Exercise Specialist									
Cardiac Rehab Nurse									
Exercise Specialist									
Midwifery Services									
Psychologist									
Other {specify}									
Other {specify}									
Other {specify}									
Other {specify}									
Other {specify}									
Other {specify}									
Total Direct Care Provider	**46.20**	**4,735,866**	**67**	**44.50**	**4,607,992**	**65**	**45.70**	**4,631,476**	**60**
Clinical Support Staffing									
Referral Coordinator									
Medical Office Assistant									
Facilitator									
Program Manager/Coordinator									
Clinical Coordinator									
Clinical Management									
Measurement and improvement	5.00	436,000	5	4.40	384,304	5	4.40	421,491	5
Total Clinical Support Staffing	**5.00**	**436,000**	**5**	**4.40**	**384,304**	**5**	**4.40**	**421,491**	**5**
Admin and Support Staffing									
Administrative Lead - Salary	1.00	161,000	1	1.00	186,439	1	1.00	168,425	1
Administrative Lead - Benefits	-	34,000	-	-	39,372	-	-	35,568	-
Other Management	3.00	352,000	3	2.90	336,223	3	2.70	322,036	3
Finance									
Human Resources									
Administrative Assistant	3.00	224,000	3	3.00	222,275	3	3.20	218,869	4
Information Technology									
Research									
Evaluation									
Communications									
Communications									
Other {specify}									
Other {specify}									
Other {specify}									
Total Admin and Support Staffing	**7.00**	**771,000**	**7**	**6.90**	**784,309**	**7**	**6.90**	**744,898**	**8**
Total PCN Staffing	**58.20**	**5,942,866**	**79**	**55.80**	**5,776,605**	**77**	**57.00**	**5,797,865**	**73**

Palliser PCN
Details Required by PPHS on Line Items (Unaudited)
For the Year Ended March 31, 2026

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

Statement of Operations

Line item	Description	Breakdown
B15	Shared Services	Not applicable
B30	Zonal Expenses	Not applicable
B37	Other Management - Salaries	-
	Patient's Medical Home Optimization Director (1.0 FTE)	128,524
	Clinical Supervisors (1.9 FTE)	173,042
		-
	Total	301,566
B38	Other Management - Benefits	-
	Patient's Medical Home Optimization Director (1.0 FTE)	15,628
	Clinical Supervisors (1.9 FTE)	19,029
		-
		-
		-
	Total	34,657
B39	Administration	-
	Board meeting stipends - Physicians	24,059
	Payroll - Exec assistant, Admin assistant, Finance Clerk (3.0 FTE)	222,275
	Professional Services -legal, accounting, HR, etc.	46,640
	Insurance, computers, telephones, office supplies	78,620
	Central Office – rent, utilities, janitorial	85,073
	Total	456,667
B41	Support Services	Not applicable

Schedule 1: Expenses by Object

Line item	Description	2026 Actual
A8	Physicians: Clinical	Not applicable
A10	Physicians: Administrative	
	Board meeting stipends	24,059
	Supervision/program planning stipends	169,589
	The payments made were in accordance with the payment criteria in the 2024-2027 business plan and the 2025/2026 budget.	-
	Total	193,648
A11	Physicians: Other	
	Office Rental/clinic supports	134,589
	Education/training/QI stipends - Physicians	48,970
	The payments made were in accordance with the payment criteria in the 2024-2027 business plan and the 2025/2026 budget.	-
	Total	183,559
A16	Alberta Health Services - Other	Not applicable
A19	Other Expenses	
	Education, training and orientation	106,715
	Medical & IT equipment and renovations	25,227
	DynaMed & ScreenCloud subscriptions	36,735
	RNs/OHCP: Travel and other supplies	46,439
	Measurement and Improvement: Payroll (4.4 FTE)	384,304
	Measurement and Improvement: Travel and other supplies	56,467
	Administrative Lead: Payroll & benefits	225,811
	Other Management: Payroll & benefits	336,223
	Payroll - Exec assistant, Admin assistant, Finance Clerk (3.0 FTE)	222,275
	Professional Services -legal, accounting, HR, etc.	46,640
	Insurance, computers, telephones, office supplies	78,620
	Central Office – rent, utilities, janitorial	85,073
	Total	1,650,529

Palliser PCN
Variance Analysis (Unaudited)
For the year ended March 31, 2026

Statement of Operations	2026 INTERNAL (Unaudited) Variance	% of budget	note req.	Explanation of variances in the Statement of Operations
Revenue				
Per Capita Funding - Operating	13,241	0%	No	Expenses were higher than budgeted. Therefore, revenue (deferral method) is higher.
Per Capita Funding - Capital	-	-%	n/a	
Interest and Investment Income	(18,045)	-27%	Yes	Interest rates decreased, therefore interest income decreased.
Fee For Service	-	-%	n/a	
PCN Nurse Practitioner Support Program (NPSP) Funding	(31,334)	-27%	Yes	There were less Nurse Practitioner staff and therefore grant funding decreased for the year.
Shared Services (Specify in Notes)	-	-%	n/a	
AH-AMA Agreement PCN Investment	-	-%	n/a	
Operational Stability Fund	(330,000)	-100%	Yes	Operational Stability Fund revenue (deferral method) was less than anticipated, due to reduced expenses.
Total Revenue	(366,138)	**-5%**	Yes	
Expenses (Priority Initiatives)				
Professional Support Within Health Homes	211,648	4%	No	There were staff vacancies during the year.
Measurement & Practice Improvement	75,857	14%	Yes	There were less Physician stipends for QI training.
PCN NPSP	31,334	27%	Yes	There were less Nurse Practitioner staff and therefore expenses decreased for the year.
Zonal Expenses (Specify in Details tab)	-	-%	n/a	
Priority Initiative Subtotal	**318,839**	**5%**	**Yes**	
Expenses (Central Allocations)				
PCN Administrative Lead Salary	**(25,439)**	-16%	Yes	This 1.0 FTE position is employed by AHS, and the salary/benefit costs are billed monthly to the PCN. The variance relates to the budget being lower than the actual cost of the position.
PCN Administrative Lead Benefits	**(5,372)**	-16%	Yes	
Other Management Salaries (Specify in Details tab)	**16,434**	5%	Yes	There was a staff vacancy during the year.
Other Management Benefits (Specify in Details tab)	**(657)**	-2%	No	
Administration (Specify in Details tab)	**62,333**	12%	Yes	There were reduced costs for professional services and Board stipends during the year.
Information Technology	**-**	-%	n/a	
Support Services (Specify in Details tab)	**-**	-%	n/a	
Amortization	**-**	-%	n/a	
(Gain)/Loss on disposal of Capital Asset(s)	**-**	-%	n/a	
Central Allocations Subtotal	**47,299**	**4%**	**No**	
Total Expenses	**366,138**	**5%**	**Yes**	There were staff vacancies during the year.
Excess/(Deficiency) of Revenue Over Expenses	**-**	**- %**	**n/a**	

Schedule 1 - Expenses by Object	2026 INTERNAL (Unaudited) Variance	% of budget	note req.	Explanation of variances in Schedule 1
Physicians: Administrative (Specify in Details tab)	49,352	20%	Yes	Board stipends were lower than budgeted for the year.
Physicians: Other (Specify in Details tab)	46,441	20%	Yes	Education/training stipends were lower than budgeted for the year.
Physicians Subtotal	**95,793**	**20%**	**Yes**	Board stipends and Education/training stipends were lower than budgeted.
Alberta Health Services - Purchased Services	-	-%	n/a	
Alberta Health Services - Office Space	-	-%	n/a	
Alberta Health Services - Other (Specify in Details tab)	-	-%	n/a	
Non-Physician Direct Care Providers	127,874	3%	No	There were staff vacancies during the year.
Zonal Expenses	-	-%	n/a	
Other Expenses (Specify in Details tab)	142,471	8%	Yes	There were staff vacancies during the year, and professional services were lower than budgeted.
Amortization	-	-%	n/a	
Total Expenses	**366,138**	**5%**	**Yes**	

Other Statements and Schedules	Explanations
Staffing summary	The physicians choose the employee type that they wish to access within their clinic. For 2026: - The relative mix between RNs and BHCs chosen by clinics was comparable to budget. - There was overall lower FTE than budgeted for the year.

Palliser PCN
Board of Directors Composition as of March 31, 2026
Legal Model 2

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

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

Director Name	Director Role (as per Articles of Association)	NPC or AHS or Community	Length of term	Term Set to Expire	Additional Information
Dr. Donovan Nunweiler	Chair	Physician group	3 years	Jul 2027	
Dr. Gerry Prince	Vice Chair	AHS	3 years	Jul 2029	
Dr. Ahmed Al-Abayachi	Director	Physician group	3 years	Jul 2027	
Dr. Gloria Tainsh	Director	Physician group	3 years	Jul 2028	
Dr. Waltie (Petrus) Vermeulen	Director	Physician group	3 years	Jul 2028	
Dr. Tobi Owolabi	Director	Physician group	3 years	Jul 2028	
Dr. Thomas Mohanraj	Non-Voting Director	Physician group	1 year	Jul 2026	
Trevor Inaba	Director	AHS	3 years	Jul 2028	