Palliser PCN

Renewed
BUSINESS PLAN

Version 4.0

April 1, 2021 to March 31, 2024

Table of Contents

Summary of PCN Key Information

Name of the PCN:	**Palliser Primary Care Network**		
Geographic Area:	South Eastern Alberta (including Bassano, Bow Island, Brooks, Medicine Hat and Oyen)		
Proposed Term of Plan:	April 1, 2021 to March 31, 2024	**Provincial Legal Model:**	#2

Number of:	**Clinics**	**Core Physicians**	**Panel # of Patients per last management report from AHW of** April 2021	**Total Population in PCN area:**
Participating in PCN	41	91		
Within PCN Geographic Area	41	97	106, 260	113,600

Anticipated Direct Care Provider Staffing[1] (FTE) for fully implemented plan:	51.50 FTE
39.95 Registered Nurses 1.65 Nurse Practitioners PCN NP support Program	0.90 Dietitians 9.00 Registered Social Worker (Behavioural Health Consultants - BHC)

All Other Anticipated Staffing (FTE) for fully implemented plan:	13.00 FTE

Clinical Support Staffing	**Administrative Staffing**	**Support Staffing**
Prof. Support in health homes 1.0 Educator *Measurement & Practice Improvement:* 1.0 PMHO Manager 1.0 Analyst 2.0 Facilitator 1.0 Assistant	1.0 Executive Director 1.0 PMHO Director 2.0 Clinical Supervisor 1.0 Exec. Assistant 1.0 Finance Clerk	

Anticipated Staffing (FTE[2]) Total for fully implemented plan	64.50 FTE

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[1] Indicates staffing by designation, allowing provincial rollup of data. Staffing by role, indicated in descriptions of Priority Initiatives (Sections 3.2, 3.3, etc.), is less accurate when rolled up due to customization to local conditions.

Executive Summary

1. Overview and Objectives

The Palliser Primary Care Network (PCN) received approval of its initial Business Plan in August 2006 and its fourth renewal Business Plan in April 2018 (covering the period April 2018 to March 2021). Over 93% of local Family Practitioners have joined the PCN, and the vast majority of these physicians have an RN or other professional working with them in their clinics delivering complex and comprehensive care, disease prevention, and health promotion, towards development of Health Home(s).

Within the PCN geographic area, a full range of comprehensive Outpatient Programs are provided by Alberta Health Services (AHS). Additionally, a broad range of not-for-profit organizations are available to support the holistic needs of the population.

There are an estimated 113,600 residents living in the area served by the PCN. PCN enrollee count at October 2020 is 107,458. Within the PCN, there is a higher percentage of patients over 65 than the provincial average (17.7% within the PCN compared to 13.0% for the province). The average age is also higher (41.8 years vs 38.4 provincially). This results in greater service needs for chronic disease management. Approximately 38,600 PCN patients have a major, moderate or minor chronic condition or an “other mental health” condition as their most complex health condition. Last year, PCN RNs/OHPs saw approximately 30,000 unique patients for over 84,000 visits. This included 8,150 BHC visits with 2,900 patients.

Eligibility for PCN professional staffing is determined by assessing an interested physician’s profile of family practice and reviewing their PCN-measured EMR-sourced family practice panel, with cross-panelled patients removed. As of April 1, 2021, the PCN will perform an assessment to identify each physician's profile based on the EMR family practice panel. Any physician who will need to make an FTE reduction will have a 2 year notice period. During this 2 year notice period the PCN will offer support and strategies to increase their EMR family practice panel.

The PCN seeks to align with at least one of the four PCN Provincial Objectives: Accountable & Effective Governance, Strong Partnerships & Transitions of Care, Health Needs of the Community and Population and Patient’s Medical Home. The overarching four priority areas outlined in the Zone Service Plan are integrated into the PCN’s Priority Initiatives.

2. Priority Initiatives

The following are the key initiatives of the Palliser PCN:

A. Professional Support in Health Homes

- This is accomplished primarily through the addition of RNs/Other Professionals to physician offices. The principal focus for these individuals is the delivery of complex and comprehensive care, disease prevention, and health promotion, towards development of the Health Home. (Per business plan = approximately 80% of the PCN budget).

B. Measurement & Practice Improvement

- Implementation of measurement, EMR optimization and practice improvement processes in physician offices (Per business plan = approximately 7.5% of PCN budget).

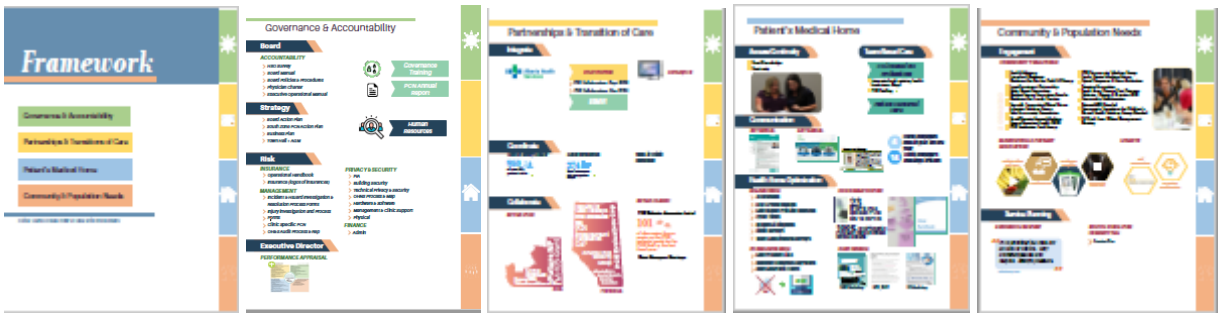
The four overarching priority areas outlined in the PCN South Zone Service Plan are integrated into the PCN’s Priority Initiatives. These include:

1. Continuity of Care: Supporting relational, informational, and management continuity.
2. Building Capacity: Identifying and understanding existing promising practice. Facilitate education and support implementation of promising practice.
3. Quality Improvement: Encourage practice improvement in the Patient’s Medical Home (PMH) to support patients with transition, prevention and management of addiction and mental health.
4. Integration: Facilitate identification and understanding of best practices approaches while spreading promising practice tools and models.

3. Governance

The PCN is overseen by a Board comprised of local physician and AHS representatives. During the 2018-2021 business plan the PCN recruited an independent director on the PCN Board. The fundamental premise of the business plan development and of PCN Board decisions is that consensus is achieved between physicians and AHS. The Board has engaged an Executive Director to provide administrative leadership and handle the day to day operations of the PCN. Board members receive internal governance training upon joining the PCN Board and the PCN supports Board members to participate in the provincial governance training. Additionally, the Board holds time on monthly board agendas, as time permits, for governance development. The PCN Board has a dispute resolution process. There is a Physician–PCN Charter defining the commitment of the PCN and participating family physicians and there are consequences for failure to meet obligations.

The PCN is developing a Framework to guide its activities to meet the four PCN Provincial Objectives:



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

4. Budget

The PCN is funded by per capita payments from the Alberta government of approximately $6.6 million per year. These payments are based on the number of informal enrollees assigned to physicians participating in the PCN. The PCN anticipates that it will operate a balanced budget over the course of the three year business plan period.

5. Local Health Issues

Approximately 38,600 PCN patients have a major, moderate or minor chronic condition or an “other mental health” condition as their most complex health condition.

The two identified Zone Service Plan Priority populations:

- Complex Patients
- Addictions and Mental Health Patients

have been incorporated into the PCN’s Priority Initiatives.

Last year, PCN RNs/OHPs saw approximately 30,000 unique patients for over 84,000 visits. These are predominantly complex patients. This included 8,150 BHC visits with 2,900 patients. These are predominantly patients with Addiction and Mental Health concerns or risks.

6. Evaluation

Overall PCN success will be measured by the successful implementation of inter-professional Health Home teams, the delivery of quality care to a defined population, a demonstrated improvement in appropriate access to quality primary healthcare resources and the maintenance of a high level of satisfaction for physicians with the delivery of primary care services.

The PCN does not consider evaluation to be a separate exercise in and of itself but rather a component of a continuous improvement program.

The guiding principles for the PCN’s evaluation plan have remained focused on striving for evaluation efforts to produce data which not only meets the needs of the PCN and AH, but, most importantly is informative to the clinic regarding the service the clinic is providing and/or the health and wellbeing of the patients to whom the clinic provides service. The PCN has continued to ensure it is meeting the expectations of the patients, physicians and employees of the PCN through the use of surveys. As well, the clinics who have participated in formal practice

improvement learning sessions (AIM and PCN Health Home Development Series) are supported to measure and evaluate their access and efficiency within the clinic. This work continues to grow incrementally throughout the PCN. Each clinic is supported by the PCN to measure at the complexity level that the PCN and clinic are able to support. The evaluation model and priorities of the PCN are made through ongoing discussions with Alberta Health Services, the participating physicians, the PCN Employees and clinic staff. The PCN will endeavor to meet mandatory Schedule B reporting requirements.

During the course of the 2021-2024 Business Plan, the PCN will continue to assist clinics to optimize EMRs and measure for improvement purposes – this will have the side effect of facilitating more accurate measurement aggregated at a PCN level. Although some clinics are being assisted to review population data from external sources like the HQCA, the majority of actionable data is pulled directly from each clinic's electronic medical record. This approach will ensure that measurement is part of clinical practice and is used to inform clinical practice rather than becoming an activity unto itself.

The PCN has developed plans for evaluation and has organized them by Provincial Objective. Selected highlights from the Evaluation section of the Business Plan are below.

Objective 1: Accountable and Effective Governance

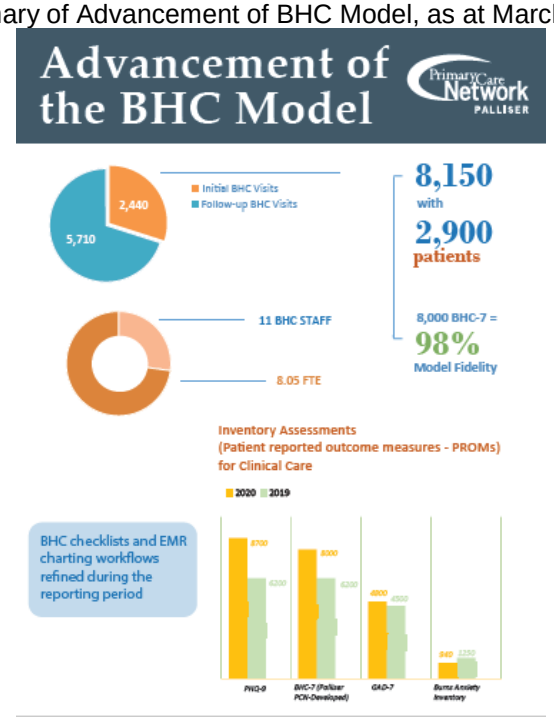
- Sample Governance Accountability infographic:

Objective 2: Strong Partnerships and Transitions of Care

- Summary of EMRs used in Palliser PCN and electronic form support (95% of clinics with PCN remote access)

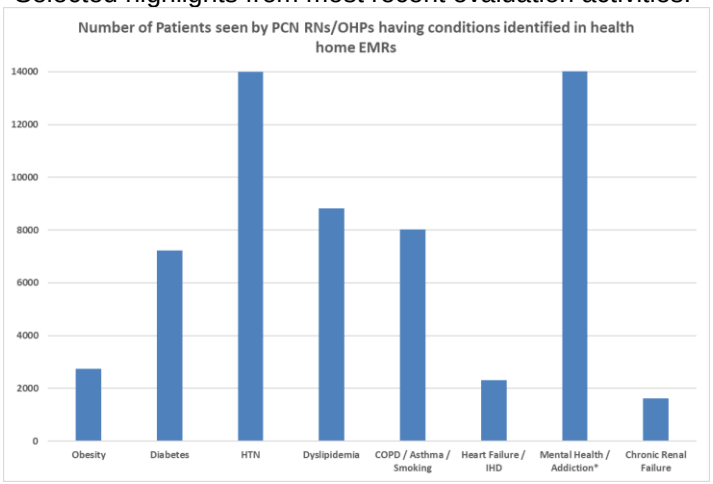
Objective 3: Health Needs of the Community and Population

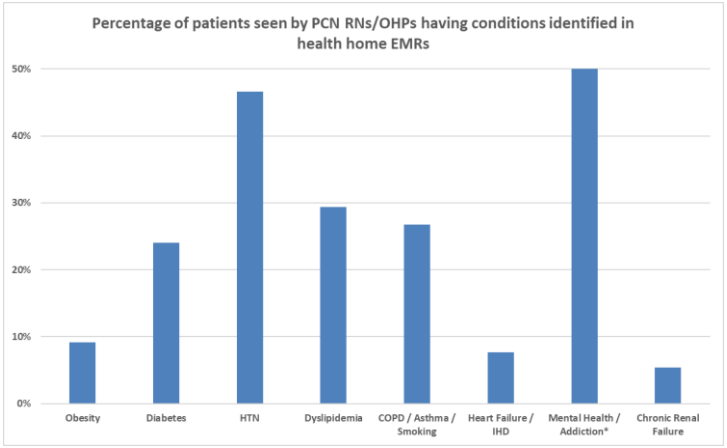
- Summary of Advancement of BHC Model, as at March 2020:

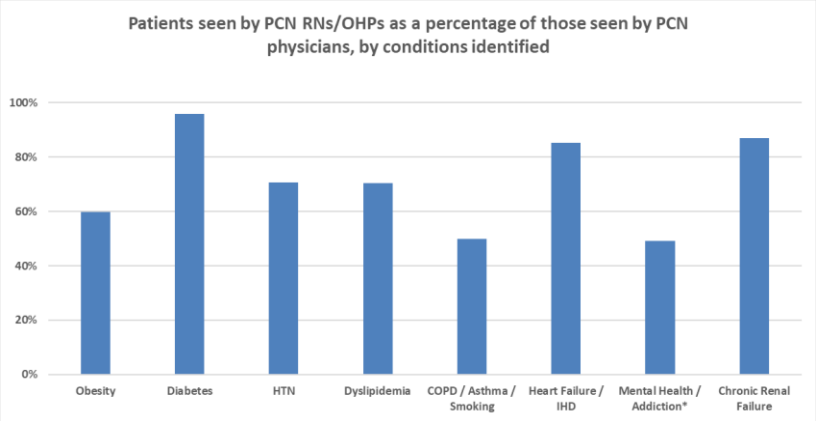


Objective 4: Patient's Medical Home (PMH)

- Selected highlights from most recent evaluation activities:







Domain	Measure	Seen by RN/OHP	Seen by Physician
Hypertension screening	% of patients seen with BP charted in last year	83%	74%
Hypertension management	% of patients with hypertension seen with most recent BP <140/90 (controlled)	89%	83%
	% of patients with hypertension seen but missing BP in last year	6%	14%
Diabetes screening	% of patients seen with A1C or FBS in last 5 years	94%	86%
Diabetes management	% of diabetic patients with A1C in last year	95%	91%
	% of diabetic patients with a most recent A1C value < 7.0	48%	48%
	% of diabetic patients with a most recent A1C value < 8.0	72%	70%
	% of diabetic patients with a most recent A1C value < 9.0	85%	82%
Tobacco use screening	% of patients seen with an identified smoking status	81%	69%
Weight management	% of patients seen with a weight measurement in last 3 years	88%	80%

The PCN is very pleased with its annual patient survey. The PCN patients selected for survey are random and the responses received are confidential. With a response rate of 78% and a total of 1467 responses received (representing about 5% of the patients that are seen by PCN RNs/OHPs), the PCN feels that it receives very valuable feedback from its most important stakeholder.

1. Overview of Local Environment

1. Geography and Population:

The PCN covers the patient population in a geographically distinct area in south-eastern Alberta. The PCN has used Statistics Canada Census and Population Estimate numbers from 2016 to 2019 to arrive at a 2020 population estimate of 113,600 residents in the area served by the PCN.

The population resides in the following communities:

Bow Island and area	Total population approx. 6,200
Brooks, Bassano and area	Total population approx. 25,000
Medicine Hat and area	Total population approx. 79,500
Oyen and area	Total population approx. 2,900

PCN enrollee count at Oct 2020 is 107,458. Using the population estimate above, there are:

- ~ 107,458 enrolled patients (95% of population): enrolled to a Palliser PCN provider
- ~ 6,142 "un-enrolled" patients (5%). This comprises patients that are:
    - Not enrolled **and without a family doctor** (i.e. "unattached") and either:
        - Seeking a family doctor in the area served by the PCN
        - Not seeking a family doctor in the area served by the PCN
    - Not enrolled **but with a family doctor in the PCN** ("attached" but not enrolled) and either:
        - With no visit to a family doctor in the last 3 years (e.g. young, healthy males)
        - Having only recently (<3 years) obtained a family doctor in the PCN*
          *In consideration of the delay for patients to be enrolled to a new provider using the Alberta Health 4-cut process
    - Enrolled elsewhere (i.e., not enrolled to Palliser PCN), either:
        - To a non-PCN provider in the area served by the PCN (N.B. the number of non-member physicians in the geographic area served by the PCN *who have an active family practice* is minimal or nonexistent)
        - To a provider in an area not served by the PCN (e.g. Taber, Strathmore)

It would be challenging to survey the "unattached" patients (option A in the above list), given the inability to specifically identify them in any data sets available to the PCN. For example, Alberta Health does not provide the PCN with a list of patients who are enrolled to the PCN – only aggregate counts by physician. As a result, it is not possible to estimate the distribution of these patients into the subcategorizations above in order to know how many patients do not currently have a family doctor. Other comments:

- During FY 2019/20, there were approximately 6 PCN physicians accepting new patients at any time. The Palliser PCN website homepage link listing this information has been updated monthly since 2015. Last year, there were 950 monthly patient visits to this homepage link. The listing is also distributed to:
    - emergency departments
    - walk-in clinics
    - Stabilization & Transition Clinic
    - 38 different community resources (email)
    - Alberta Find-A-Doc website administrators
- These steps – to widely list physicians currently accepting new patients – have been taken to minimize the number of patients in the area served by the PCN who are seeking a family doctor and cannot do so.

According to HQCA data, approximately 10% of Albertans are "Health system non-users" (please see HQCA Burden of Illness table, page 6). Given that these patients, by definition, have not had an interaction with a GP, specialist, urgent care, emergency departments or hospitals in a 3 year period, they cannot be enrolled to any PCN in the province. Therefore, it should not be surprising if there is a difference of 10% between geographic population and PCN enrollee count. As indicated above, *there is currently a 6% difference between Palliser PCN area population estimate and enrollee count.*

Data sources considered in measuring geography and population distribution were:

- Statistics Canada 2006, 2011, 2016 Censuses, 2015-2019 Population Estimates, Annual Demographic Estimates
- HQCA Palliser PCN-level proxy report (data up to March 31, 2019)
- Alberta Health PCN and LGA Community Profiles (last updated 2018 and 2019; latest population data from 2016 and 2018)
- Alberta Government Population Estimates (latest regional estimates to 2018)

- Palliser PCN clinic Electronic Medical Record (EMR) systems (97% of clinics with an EMR providing access to the PCN)
- Alberta Health Interactive Health Data Application (some data up to 2018, 2019)

2. Pertinent demographic characteristics

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

Under 1:	0.9%
1 to 17:	18.0%
18 to 34:	21.1%
35 to 64:	42.1%
65 to 79:	13.2%
80 +	4.5%

Within the PCN, there is a higher percentage of patients over 65 than the provincial average (17.7% within the PCN compared to 13.0% for the province). The average age is also higher (41.8 years vs 38.4 provincially). This results in greater service needs for chronic disease management.

(HQCA 2018/19 report provided March 2020)

Within the PCN, there are small Mennonite and immigrant communities.

3. Health Status – Specific Health Needs in Health Homes

PCN-level analysis:

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

Chronic Disease

Use of the Alberta Health Community Profile data sets presents challenges for the following reasons:

- Not updated since 2018 (PCN profile) or 2019 (Local Geographic Area profiles), using data up to March 2016 and 2018, respectively
- Profiles estimate a PCN area population of 116,300 (Local Geographic Area profiles) or 104,000 (PCN profile); disparity with the 2016 StatsCan population estimate for the PCN area of 112,800 causes uncertainty regarding data accuracy, as do disparities between chronic disease incidence between AH and HQCA data (e.g. COPD incidence of 3.5% vs 5.8%, respectively).
- The PCN must consider either 5 separate community profiles or the PCN-level profile.

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

	Community (LGA) Profiles							**PCN-level Profile**	
Chronic Disease Prevalence (%)	**Alberta**	**Medicine Hat**	**Cypress County**	**Newell**	**Oyen**	**County of Forty Mile**	**Average across PCN area**	**Alberta PCNs**	**Palliser PCN**
Hypertension	20.6	21.1	21.0	25.9	23.6	20.9	22.3	18.4	20.2
Diabetes	8.0	8.1	8.0	9.4	7.7	6.7	8.3	7.1	7.6
Ischemic Heart Disease	4.1	6.4	6.3	5.1	4.7	4.4	5.9	3.3	4.7
COPD	3.0	4.1	3.9	4.9	3.4	2.6	4.2	2.7	3.5

(AH 2015/16 Community and PCN-level Profiles, 2017-2018)

The Health Quality Council of Alberta PCN Proxy Panel Report measures a population of 103,000 which is lower than the PCN area population estimate of 113,600. An advantage of the HQCA report is that the prevalence rates are provided for each of the PCN, zone and Alberta panels. (Higher prevalence rates than provincial average are **bolded**.)

HQCA: Select Chronic Disease Prevalence (%)	Alberta	Zone Panel	PCN Panel
Hypertension	12.6	13.9	**18.4**
Asthma	10.9	11.0	**12.1**
Diabetes	7.6	8.4	**9.6**
CAD	4.9	5.7	**9.2**
COPD	3.3	3.7	**5.8**
CKD	1.4	1.8	**2.3**
CHF	1.0	1.4	**1.9**

(HQCA 2018/19 PCN-level Proxy Report, 2020)

Mental Health

HQCA: Select Mental Health Condition Prevalence (%)	Alberta	Zone Panel	PCN Panel
Depression	16.4	19.1	**23.8**
Anxiety/OCD	7.6	8.4	**9.6**
Bipolar	1.8	2.6	**4.3**
Dementia	1.1	1.5	**1.8**
Delusional Disorder	0.8	0.8	**0.9**

(HQCA 2018/19 PCN-level Proxy Report, 2020)

Patient Complexity

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

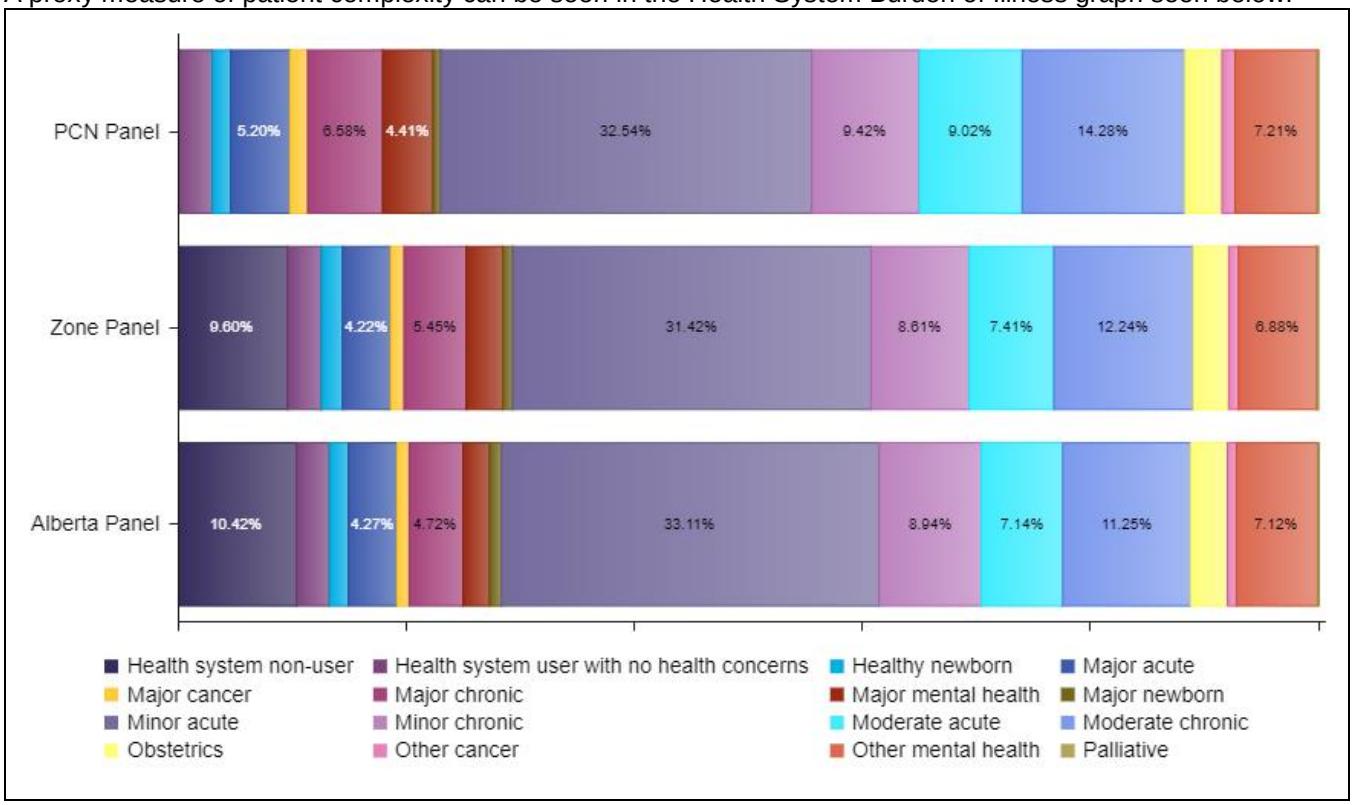


Figure 1 – Comparative complexity of patients by Health System Burden of Illness [Province, Zone, PCN]

(HQCA 2018/19 PCN-level Proxy Report, 2020)

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

Burden of Illness category	PCN Panel	Zone Panel	Alberta Panel
Palliative	0%	0%	0%
Major acute	**5%**	4%	4%
Major chronic	**7%**	5%	5%
Major newborn	1%	1%	1%
Major mental health	**4%**	3%	2%
Major cancer	**2%**	1%	1%
Moderate acute	**9%**	7%	7%
Moderate chronic	**14%**	12%	11%
Other cancer	1%	1%	1%
Other mental health	7%	7%	7%
Obstetrics	3%	3%	3%
Minor acute	33%	31%	33%
Minor chronic	9%	9%	9%
Healthy newborn	2%	2%	2%
Health system user with no health concerns	3%	3%	3%
Health system non-user	0%	10%	10%

(HQCA 2018/19 PCN-level Proxy Report, 2020)

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

- 6,800 patients with a Major chronic burden of illness
- 14,700 patients with a Moderate chronic burden of illness
- 9,700 patients with a Minor chronic burden of illness
- 7,400 patients with an “Other mental health” burden of illness

Totaling this information, one would estimate that, using the CIHI Population Grouping Methodology, 38,600 PCN patients have a major, moderate or minor chronic condition or an “other mental health” condition as their most complex health condition.

Last year, PCN RNs/OHPs saw approximately 30,000 unique patients for over 84,000 visits. This included 8,150 BHC visits with 2,900 patients.

(PCN 2019/20 Annual Report)

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

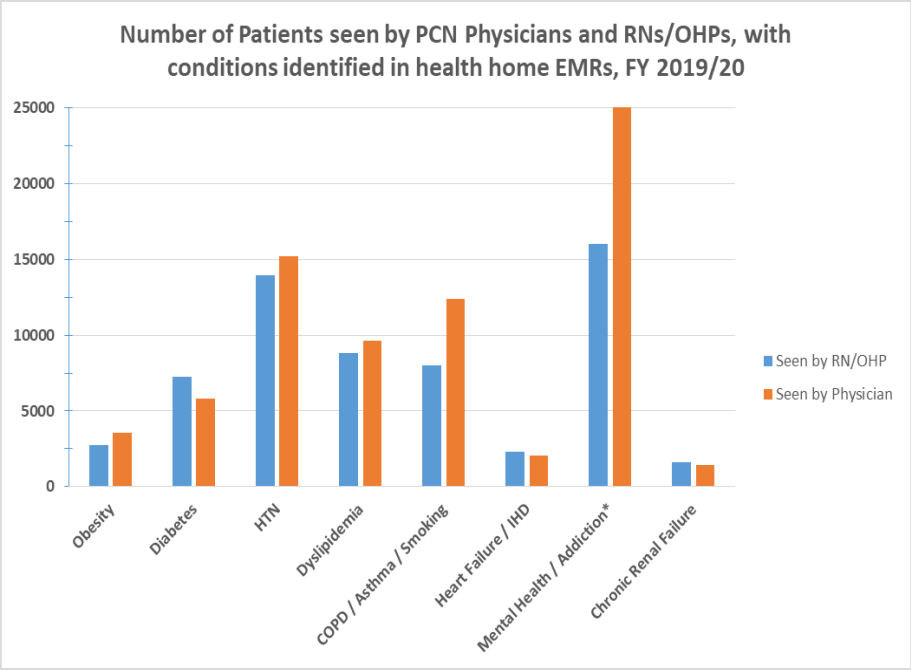


Figure 2 – Patients seen by PCN Physicians, RNs/OHPs by EMR-identified condition
* The number of patients seen with Mental Health/Addiction issues is based on billing diagnostic codes and not EMR problem list identification. This allows a more accurate count of patients experiencing these issues.

(PCN 2019/20 Annual Report)

Taken in association with HQCA disease prevalence estimates:

Condition	# of patients seen last year by PCN providers	HQCA-estimated # of patients with condition on PCN panel	Est. % of total patients seen last year
Obesity (BMI >=35)	3550	(not measured)	*(cannot be estimated)*
Diabetes	5800	9865	*59%*
Hypertension	15250	18907	*81%*
Dyslipidemia	9650	(not measured)	*(cannot be estimated)*
COPD / Asthma / Smoking	12400	(not measured in combined fashion; smoking not measured)	*(cannot be estimated)*
Heart Failure / IHD	2100	1952	*108%*
Mental Health / Addiction	25100	(not measured together)	*(cannot be estimated)*
Chronic Renal Failure	1450	2363	*61%*

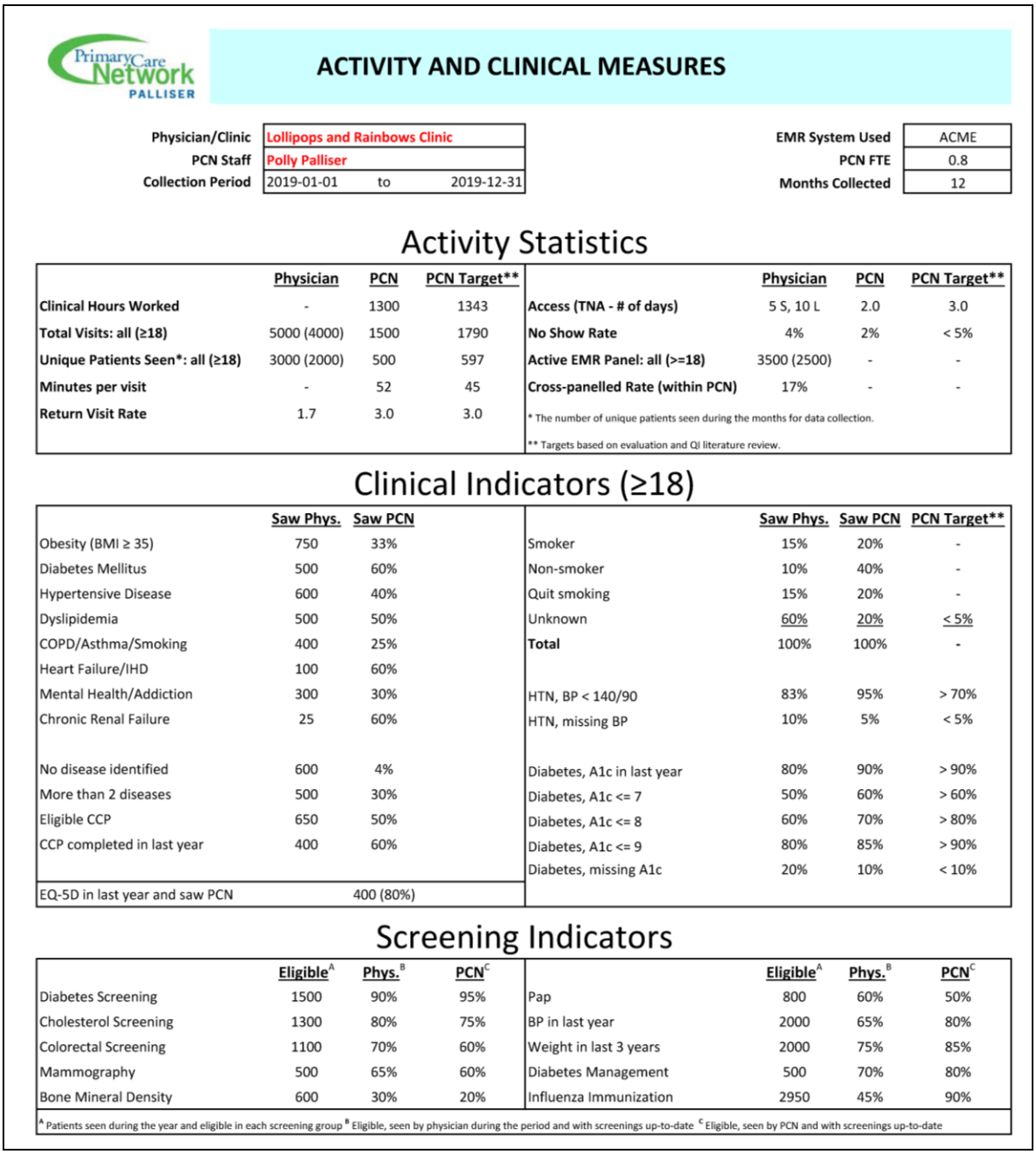
Challenges in interpretation:

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

Health Home level analysis:

The PCN has 41 unique Health Homes (clinics). Each Health Home is staffed by a team of clinical and non-clinical staff including the physician(s), PCN employees, and clinic employees. Data from the clinics' EMRs is used to determine what, if any, clinical specialization is appropriate for a given clinic panel. For example, one clinic may have a significant number of smokers and consequently choose to provide in-clinic spirometry and smoking cessation and support. This type of service would not be provided in a clinic where either this need is not identified or other needs have taken precedence.

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



ACTIVITY AND CLINICAL MEASURES

Physician/Clinic	Lollipops and Rainbows Clinic	EMR System Used	ACME
PCN Staff	Polly Palliser	PCN FTE	0.8
Collection Period	2019-01-01 to 2019-12-31	Months Collected	12

Activity Statistics

	Physician	PCN	PCN Target**		Physician	PCN	PCN Target**
Clinical Hours Worked	-	1300	1343	Access (TNA - # of days)	5 S, 10 L	2.0	3.0
Total Visits: all (≥18)	5000 (4000)	1500	1790	No Show Rate	4%	2%	< 5%
Unique Patients Seen*: all (≥18)	3000 (2000)	500	597	Active EMR Panel: all (>=18)	3500 (2500)	-	-
Minutes per visit	-	52	45	Cross-panelled Rate (within PCN)	17%	-	-
Return Visit Rate	1.7	3.0	3.0				

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

** Targets based on evaluation and QI literature review.

Clinical Indicators (≥18)

	Saw Phys.	Saw PCN		Saw Phys.	Saw PCN	PCN Target**
Obesity (BMI ≥ 35)	750	33%	Smoker	15%	20%	-
Diabetes Mellitus	500	60%	Non-smoker	10%	40%	-
Hypertensive Disease	600	40%	Quit smoking	15%	20%	-
Dyslipidemia	500	50%	Unknown	60%	20%	< 5%
COPD/Asthma/Smoking	400	25%	**Total**	100%	100%	-
Heart Failure/IHD	100	60%				
Mental Health/Addiction	300	30%	HTN, BP < 140/90	83%	95%	> 70%
Chronic Renal Failure	25	60%	HTN, missing BP	10%	5%	< 5%
No disease identified	600	4%	Diabetes, A1c in last year	80%	90%	> 90%
More than 2 diseases	500	30%	Diabetes, A1c <= 7	50%	60%	> 60%
Eligible CCP	650	50%	Diabetes, A1c <= 8	60%	70%	> 80%
CCP completed in last year	400	60%	Diabetes, A1c <= 9	80%	85%	> 90%
			Diabetes, missing A1c	20%	10%	< 10%
EQ-5D in last year and saw PCN	400 (80%)					

Screening Indicators

	Eligible[A]	Phys.[B]	PCN[C]		Eligible[A]	Phys.[B]	PCN[C]
Diabetes Screening	1500	90%	95%	Pap	800	60%	50%
Cholesterol Screening	1300	80%	75%	BP in last year	2000	65%	80%
Colorectal Screening	1100	70%	60%	Weight in last 3 years	2000	75%	85%
Mammography	500	65%	60%	Diabetes Management	500	70%	80%
Bone Mineral Density	600	30%	20%	Influenza Immunization	2950	45%	90%

[A] Patients seen during the year and eligible in each screening group [B] Eligible, seen by physician during the period and with screenings up-to-date [C] Eligible, seen by PCN and with screenings up-to-date

Figure 3 – Palliser PCN Activity and Clinical Measures Sheet (2020): Sample

(PCN 2019/20 Annual Report)

Information in this format also supports decisions regarding potential areas for clinical and process improvement at a team and individual provider level. The PCN facilitates interpretation of this information and supports development of a team's Health Home Action Plan, including periodic measurement of process and outcome measures to support a team's improvement aim. This process is summarized in the following table demonstrating the PCN's Adapted 5 A's Change Model for Health Home Optimization:

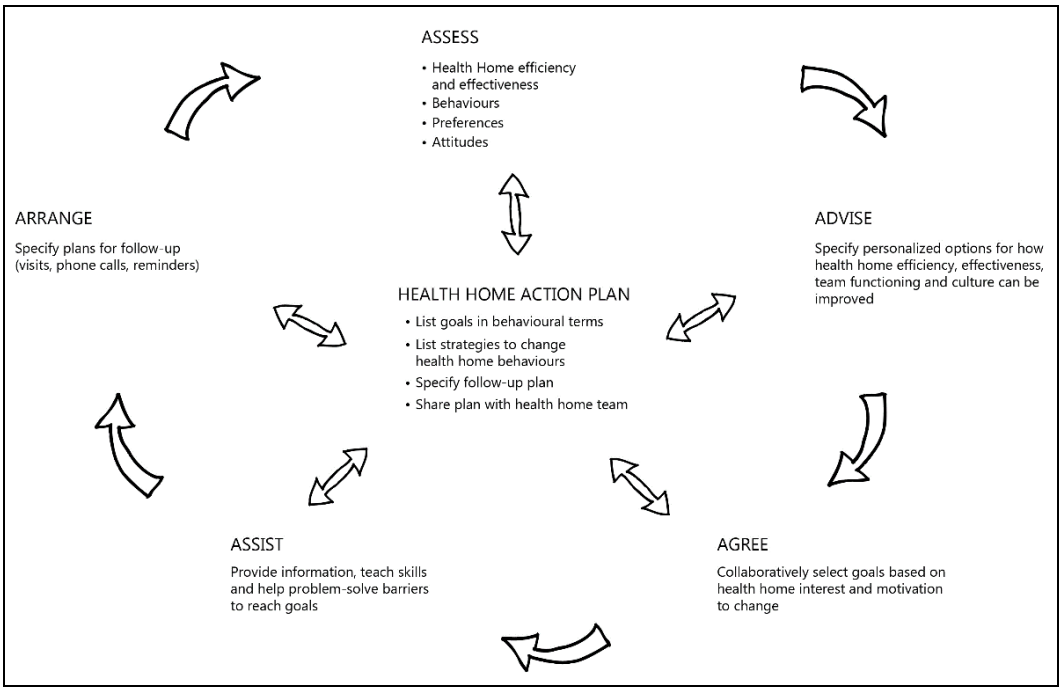


Figure 4 – Palliser PCN's 5 A's Change Model for Health Home Optimization

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

Currently operating within the PCN geographical area:

Family practitioners:	97 (approximately)
Specialists:	96 (approximately)
Non-physician providers:	Full range of other private providers including: chiropractors, optometrists, pharmacists, physiotherapists, podiatrists, psychologists, etc.

5. Available regional and community programs and facilities

Within the PCN geographic area, a full range of comprehensive Outpatient Programs are provided by Alberta Health Services (AHS). Additionally, a broad range of not-for-profit organizations are available to support the holistic needs of the population. The PCN has strong linkages with these programs through maintaining and updating an online compendium of local programs ("Local Resources") including up to date access information. This information is available on the PCN website: www.palliserpcn.ca . There are currently 274 Local Resources listed on the website and approximately 2700 annual visits to the Local Resources main listing. Additionally, the PCN hosts a Community Resource Expo in Brooks and Medicine Hat (approximately every 18 months) to enable community services to showcase their services and to meet directly with multi-disciplinary service providers. Finally, the PCN invites community services to PCN staff meetings (approximately 4-8 per year) for the same purpose.

The following local Health Facilities are funded by AHS:

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

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

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

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

Personal Family Physician:
There appears to be sufficient family physicians in the catchment area at this time. However, this situation could be impacted by physician retirements in the coming years. Additionally patients may seek care outside of their regular family physician office resulting in fragmented care.

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

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

Comprehensive Care:
Many of the Health Homes within the PCN are small teams and will be unable to provide all family practice services and public health needs within the Health Home. These services are typically available in the community; the referral, appropriate access, and information sharing with these 'outside' services can be challenging.

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

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

Education, Training and Research:
The PCN Health Homes continue to be a robust training site for medical students and residents. However, there is limited ability to accommodate other health professionals in this manner. A limited number of Health Homes engage in medical research.

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

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

7. Effect of the PCN on the Local Environment during its 2006-2021 Business Plans

A. Primary Provider: The number of patients enrolled in the PCN has continued to trend upward. A slight drop in enrollee numbers in October 2020 and April 2021 was in alignment with many other PCNs in Alberta. This is being investigated at a provincial level.

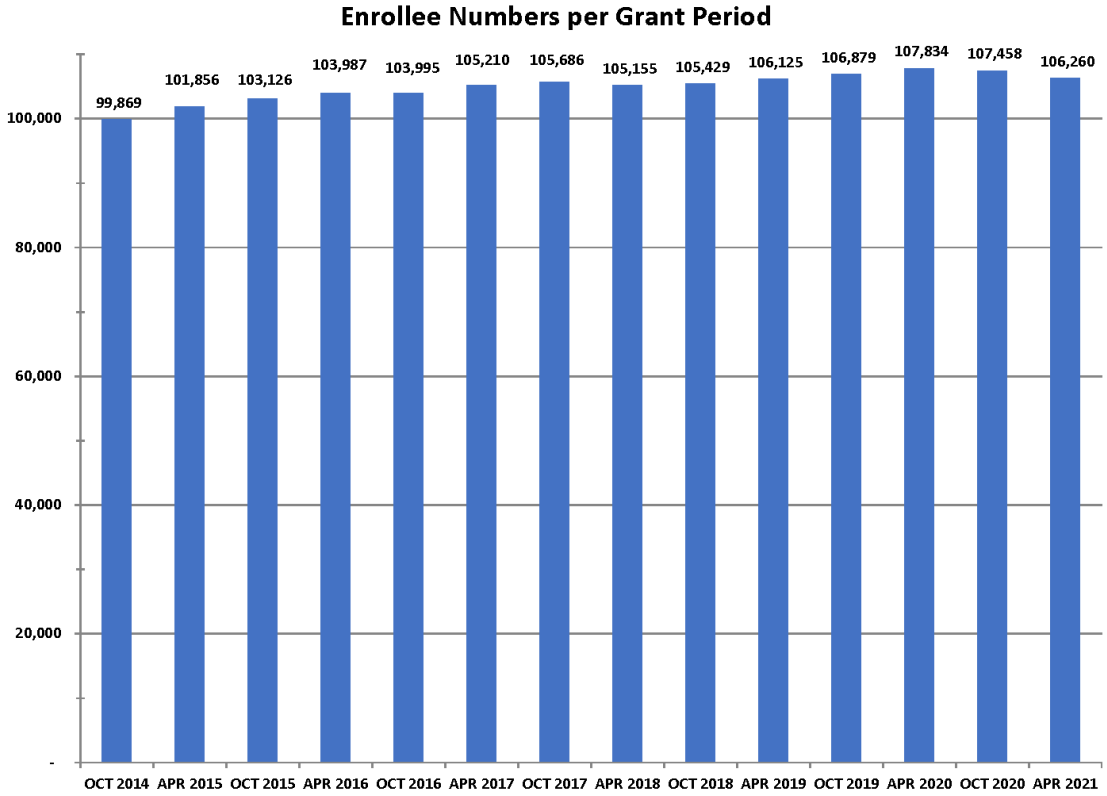


Figure 5 – Palliser PCN Enrollee Numbers per Grant Period, October 2014 to April 2021

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

<table>
<tr><th>Profile</th><th colspan="2">Definition</th><th>Eligibility for PCN professional staffing</th><th>Eligibility for PCN panel support</th></tr>
<tr><td>No Family Practice</td><td colspan="2">Physician has no family practice patients.</td><td>Not eligible</td><td>Not eligible</td></tr>
<tr><td>Minority Family Practice</td><td rowspan="2">Physician has any family practice patients.</td><td>Physician has less than 500 family practice patients.</td><td>Not eligible</td><td>Eligible for PCN Panel Optimization Coordinator*, as available from the current pool of Coordinators</td></tr>
<tr><td>Core Family Practice</td><td>Physician has 500 or more family practice patients.</td><td>Eligible, based on AH enrolled patient panel numbers as below:
<table>
<tr><th>Step</th><th colspan="2">Panel Size</th><th>FTE Allowed</th></tr>
<tr><td>1</td><td>500</td><td>900</td><td>0.5</td></tr>
<tr><td>2</td><td>900</td><td>1200</td><td>0.7</td></tr>
<tr><td>3</td><td>1200</td><td>1500</td><td>0.9</td></tr>
<tr><td>4</td><td>1500</td><td>></td><td>1.0</td></tr>
</table></td><td>Not eligible</td></tr>
</table>

*PCN Panel Optimization Coordinator: PCN employee who assists the Health Home team with panel identification, supporting unattached patients, and enrolling the team in CPAR/CII.

As of April 1, 2021, the PCN will perform an assessment to identify each physician's profile based on the EMR family practice panel. Any physician who will need to make an FTE reduction will have a 2 year notice period. During this 2 year notice period the PCN will offer support and strategies to increase their EMR family practice panel.

The PCN will be pulling this EMR data twice a year (October & April) and provide it directly to the physician member along with strategies and support from the PCN to increase and/or stabilize their panel numbers. The PCN will start using these physician profiles and eligibility criteria for allotting PCN employees to individual Health Homes (physicians) as of April 1, 2021.

B. Chronic Disease Management: Within the PCN, over 94% of physicians are now working in a clinic with a RN/OHP assisting to provide comprehensive chronic disease management. Patients seen by RN/OHP are receiving comprehensive care and have experienced improved health and/or wellbeing in their chronic conditions. The unique patients seen by all PCN RN/OHPs during 2019/20 is approximately 30,000. RN/OHPs completed an estimated 84,000 patient visits, spending on average 56 minutes per patient visit with an average annual return visit rate of 2.8.

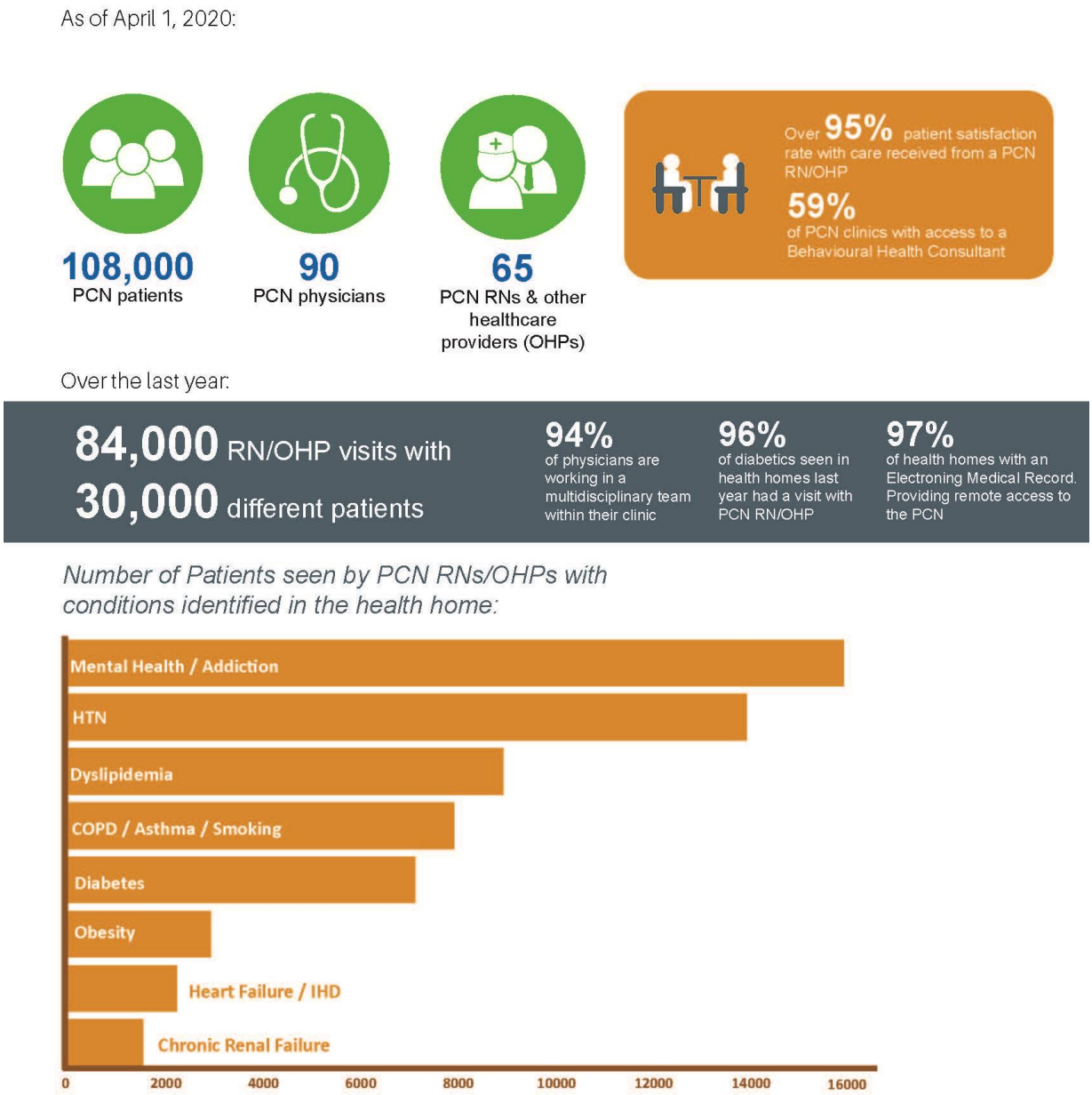


Figure 6 – PCN 2019/20 "At A Glance" Infographic, Selected Area

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

- 95% of clinics overall use an EMR for charting.
    - 92% of clinics that have an EMR for charting have provided remote access
    - 100% of clinics that have PCN professional staff and an EMR for charting have provided remote access

Figure 7 – Palliser PCN EMR Highlights, February 2021

C. Behavioural Health Consultation: Within the PCN, over 59% of clinics now have access to a BHC working with the physician to provide mental health assessment, referral and counselling. The PCN moved from a mental health counselling to a BHC model to both improve efficiency and effectiveness of mental health care in primary care.

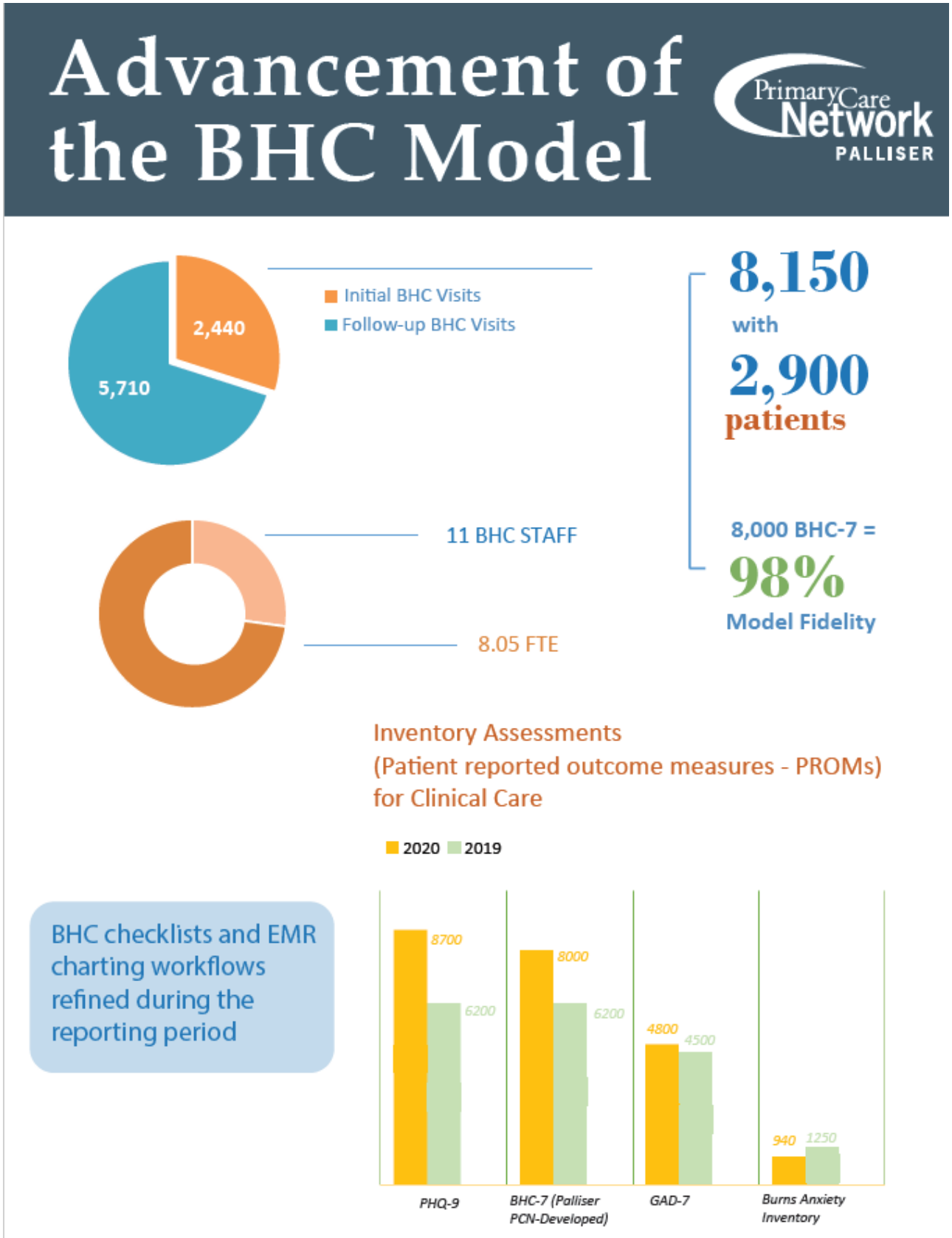
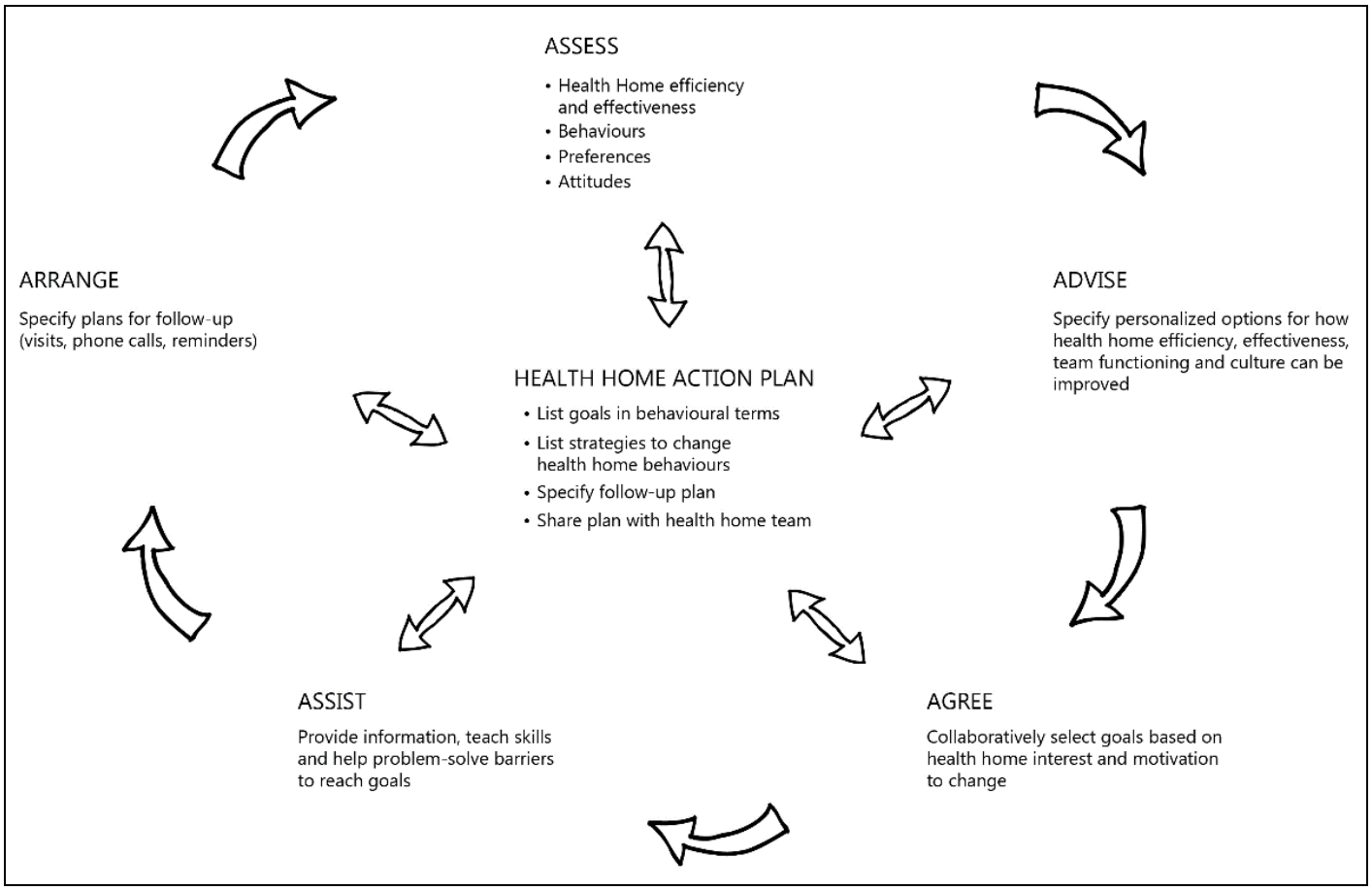


Figure 8 – PCN 2019/20 Annual Report "Advancement of the BHC Model" Infographic

D. Health Promotion / Disease Prevention: Within the PCN, RN/OHPs engage in both outreach and opportunistic prevention / screening. Additionally the RN/OHPs work with AHS programs, such as Public Health, to offer vaccinations and public health education as appropriate for the patient. The PCN also supports clinics to participate in the HUTV program (currently 11 clinics) allowing the clinic to run various health education programs which may be provided by AHS, the PCN and various external agencies. The PCN provides support to Health Homes that wish to create specific in-clinic messaging for their patients, e.g. introducing care providers, clinic policies and vacation hours.

E. Measurement and Practice Improvement: The PCN has been involved in practice improvement since 2009. During this time, 25 clinics have participated in practice improvement learning sessions. Improvements have included enhancements in office flow and efficiency resulting in reduced time waiting for an appointment with the primary care team and increased panel size for some physicians. As well, improvements in Electronic Medical Record uptake and usage have resulted in improved screening, consistency in clinical care and better linkages/follow-up. Also, continuing work on clarifying roles within the Health Home team supports ongoing improvements in efficiency and effectiveness. During this business planning period, the PCN has continued to refine its approach for moving clinics towards Health Home Optimization. The PCN has adapted the 5A's Behaviour Change model for this purpose. The below model illustrates the approach taken with the PCN Health Homes to assess, advise, agree, assist and arrange to move forward with a health home improvement action plan.



The PCN has supported continuity in the following ways:

- PCN Continuity of Care Form: sent by PCN professional staff to family doctors when a visit occurs outside of the patient's health home
- Hospital discharge follow-up: PCN professional staff assist with discharge follow-up management including updating of EMR medication lists
- Case conferencing: PCN professional staff participate in case conferencing with Home Care and LTC if the physician is unable to attend

- Face to Face networking with referral sources, e.g. at PCN Community Expos, PCN staff meetings, PCN workshops
- PCN supports within individual health homes:
    - Panel process development – scripting, contingency planning for panel needs e.g. vacation planning
    - Cross panel measurement – rates reported annually via ACM
    - HUTV messaging re: panel and "the importance of having one family physician"
    - Posters in clinic and exam rooms
    - Newsletter/Newspaper messaging (media & Internal Chronicles Newsletter)
    - CII/CPAR (2 active clinics) and socialized eNotifications to 100% of PCN Core Family Practice physicians. Information sharing via physician Town Halls. Foundational support provided via support for PIA updates and CII/CPAR application process where desired by the physician.
        - 63% of clinics have an up-to-date PIA
        - 30% of clinics currently have a PIA update in progress
    - Monthly updates of physicians accepting new patients and delivery to 40+ locations
    - HQCA reports: reviewing activity characteristics of patients including internal and external continuity

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

a. Participating in orientation of new PCN employees
b. Showcasing information/services at PCN events such as displays at PCN monthly staff meetings or quarterly workshops,
c. Where appropriate, local programs are invited to provide expert/new information at PCN learning events.
d. Where appropriate, the PCN employee is sent for training with specialists (local and provincial), opening up communication and referral opportunities.
e. The PCN maintains an online community resource compendium ("Local Resources") to support easy reference to local services and referral processes.
f. The PCN maintains a current and comprehensive website where patients and health care providers are able to find information regarding resources.
g. The PCN works with local programs (AHS and Community NPCs) to develop improved handoffs.

G. Physician Engagement: Physician engagement remains high in the Palliser PCN with physicians having easy and appropriately responsive access to the PCN central office team. 2020 physician surveys (response rate of 86%, overall satisfaction rate of 85%) reported the following:

PCN Communication: *"I have been satisfied with the communication from the PCN"* resulted in an average rating score of 87%.

PCN Practice Improvement Support: *"I have been satisfied with the amount and type of practice improvement support provided by the PCN"* resulted in an average rating score of 84%.

PCN Financial Management: *"I have been satisfied with the PCN's financial management"* resulted in an average rating score of 78%.

PCN Staff Support / Education: *"I have been satisfied with the amount and type of support and education that PCN staff receive from the PCN"* resulted in an average rating score of 86%.

2. History, Vision, and Objectives of the PCN

1. History (How the PCN came into Existence)

October 2005 to May 2006:

- The initial Palliser PCN business plan was created by a development committee comprised of local family physicians and a Health Region representative.

August 2006: The Palliser PCN was approved to begin operations.

August 2006 to date: The PCN incrementally hired staff and implemented its programs over the last 14 years. Development has been achieved through feedback from patients, physicians and PCN staff, to ensure that the PCN is singularly focused on delivering primary care services that are of the most benefit to the community.

June 2019 to December 2020: The business plan renewal process for 2021 to 2024 was completed:

- Three PCN Physician Town Halls were conducted (January, June and October 2020) to help physicians understand the PCN Provincial Objectives and help the PCN Board shape the business plan.
- Surveys were sent to all PCN physicians and all PCN employees, requesting formal feedback on improvements that could be made to PCN services. The physician response rate for these surveys was 86% and the employee response rate was 99%.
- A survey on PCN services was conducted, with over 1450 responses received from PCN patients.
- The PCN continues to meet and gather information from local not-for-profit organizations, AHS, the Health Advisory Council and various advocacy groups such as Friends of Medicare.
- The PCN gathers high level data from various reports available.
- The PCN Board, comprised of family physicians and AHS representatives, comprehensively reviewed the PCN service delivery model and recommended a renewed business plan to the physicians, AHS and AH for approval.

PCN Vision, Mission, Purpose and 2020/2021 PCN Board Priorities

- 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.
- 2020/2021 Priorities:
    - Physician and team awareness and engagement
    - Clinic improvements
    - Staff retention
    - Physician wellness and pride

2. Alberta Health PCN Objectives (How the PCN supports them)

The PCN is developing a Framework to guide its activities to meet the four PCN Provincial Objectives:

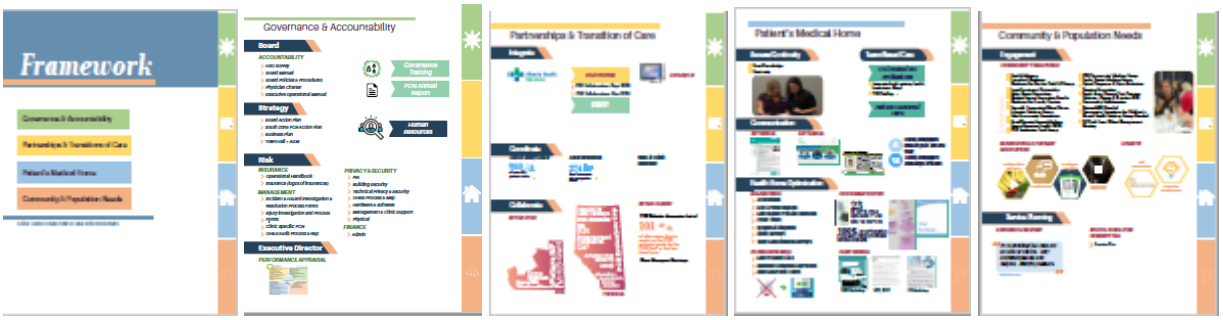


Figure 9 – Palliser PCN Framework: stratifying PCN activities with the four PCN Provincial Objectives

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

1. **Accountable & Effective Governance:** Establish clear & effective governance roles, structures & processes that support shared accountability & the evolution of primary healthcare delivery.

Governance & Accountability

Board

ACCOUNTABILITY

- *HSO Survey*
- *Board Manual*
- *Board Policies & Procedures*
- *Physician Charter*
- *Executive Operational Manual*

Governance Training

PCN Annual Report

Strategy

- *Board Action Plan*
- *South Zone PCN Action Plan*
- *Business Plan*
- *Town Hall + AGM*

Human Resources

Risk

INSURANCE

- *Operational Handbook*
- *Insurance (logos of insurances)*

MANAGEMENT

- *Incident & Hazard Investigation & Resolution Process Forms*
- *Injury investigation and Process*
- *Forms*
- *Clinic Specific PCN*
- *OH&S Audit Process & Rep*

PRIVACY & SECURITY

- *PIA*
- *Building Security*
- *Technical Privacy & Security*
- *OHNS Process & Map*
- *Hardware & Software*
- *Management & Clinic Support*
- *Physical*

FINANCE

- *Admin*

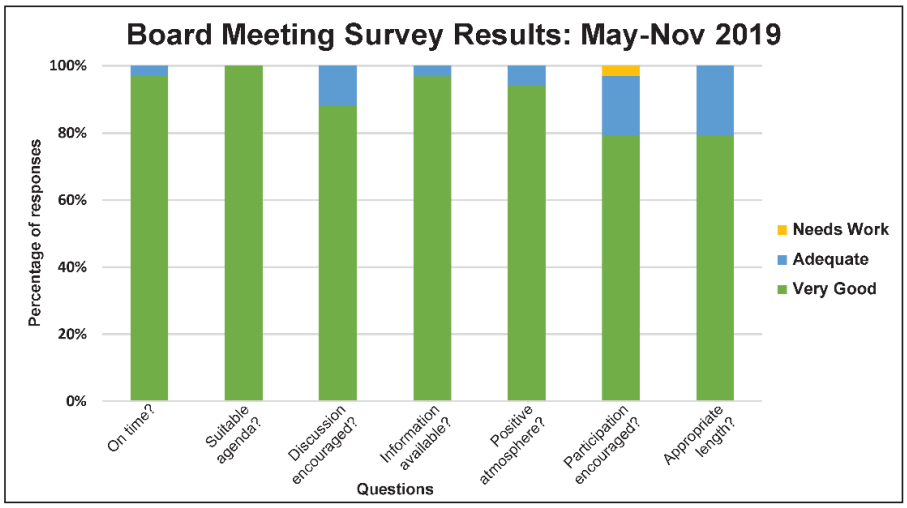
Executive Director

PERFORMANCE APPRAISAL

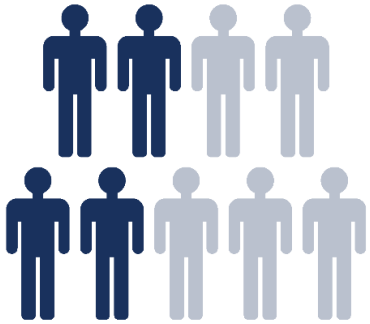
- Sample Governance Accountability infographic used by PCN Board:

Governance Accountability

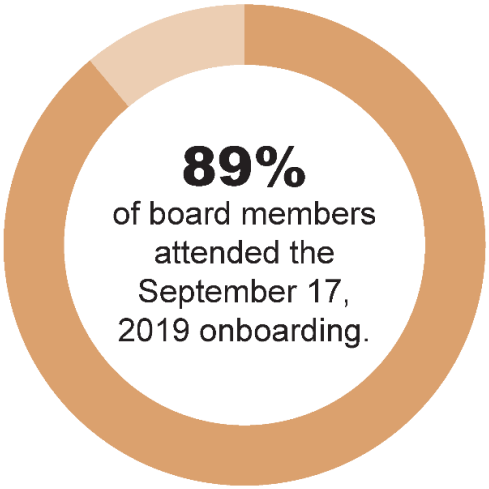
Primary Care Network PALLISER

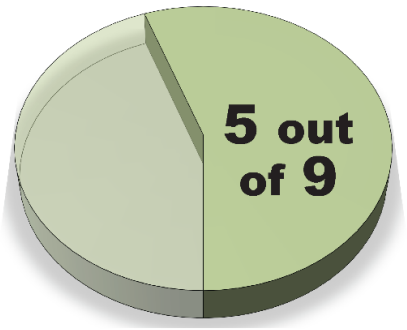


78% of board members attended the September-November board meetings, on average.



4 out of 9
board members attended the 2019 PCN Christmas Social.

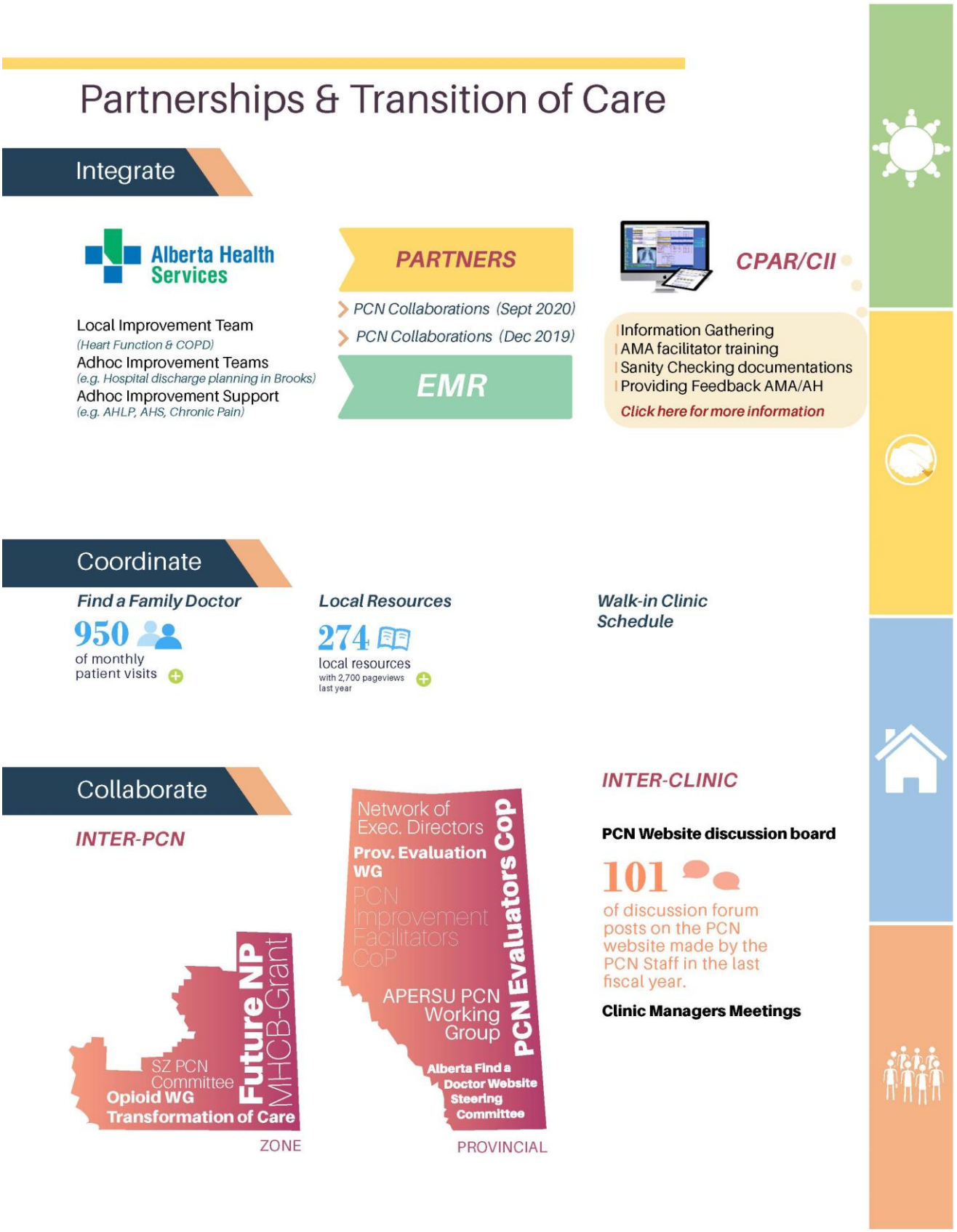




board members attended one or more AMA Board Governance Training sessions.

Goal for February 7 & 8 Leadership Forum:
100%
(22% registered)

2. **Strong Partnerships & Transitions of Care:** Coordinate, integrate & collaborate with health services & other social services across the continuum of care.



Palliser PCN Collaboration

The Palliser Primary Care Network collaborates with over 94 organizations locally, provincially and nationally.

Mental Health & Addiction
31

Chronic Pain
8

Cancer
4

Diabetes
4

Elderly & Dementia
33

Obesity
7

Cardiovascular
6

Respiratory
5

Socioeconomic Supports
28

- The PCN strives for these partnerships to be a close to the point of care as possible. Therefore the PCN facilitates front line PCN, AHS and local NPCs to share information about their services and coordinate directly regarding specific patient care needs. The PCN Executive Director has strong relationships with local not-for-profit associations which contributes to both identifying gaps and challenges in the community as well as staying abreast of changes to resources in the community.

Partners

Primary Care Network PALLISER

SAAMIS IMMIGRATION SERVICES ASSOCIATION

Medicine Hat & District Chamber of Commerce

Canadian Mental Health Association
Mental health for all

Primary Care Network Alberta Find a Doctor

Alberta Health Services
Sexually Transmitted Blood Borne Infection Working Group

Alberta Health Services
Local improvement team re: CHF,COPD Pathway

Alberta Health Services
Diabetes, Obesity and Nutrition Strategic Clinical NetworkTM

HIV COMMUNITY LINK
(prevention + support + advocacy)

BCIS

BE YOUTH CENTRE
Community Transitions for Children's Mental Health Working Group

Medicine Hat
Women's Shelter Society

Medicine Hat & Area Elder Abuse Prevention Coalition

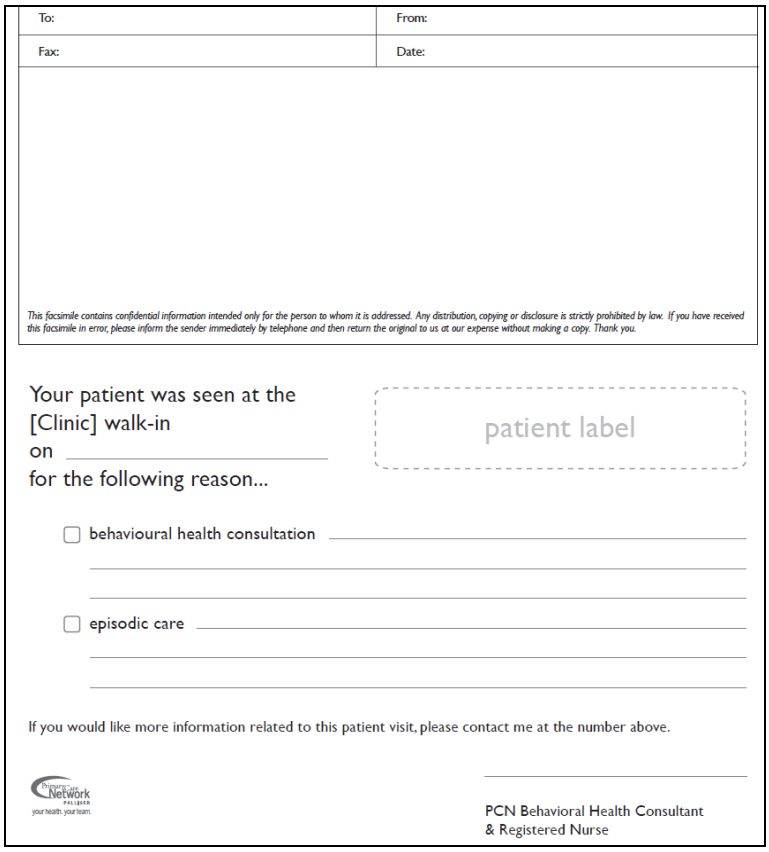
THE MUSTARD SEED

Digestive Health Strategic Clinical Network™
Rural and Remote Access Working Group

Medicine Hat collaborative community response

- The PCN hosts a Community Expo approximately every 18 months. This includes approximately 50 organizations in Medicine Hat and 25 organizations in Brooks.

- Where PCN employees see patients outside of their Health Home (i.e. a BHC sees a patient in an urgent care clinic who has a family physician in another location) the PCN sends the Health Home a communication of the service provided.



To:	From:
Fax:	Date:

This facsimile contains confidential information intended only for the person to whom it is addressed. Any distribution, copying or disclosure is strictly prohibited by law. If you have received this facsimile in error, please inform the sender immediately by telephone and then return the original to us at our expense without making a copy. Thank you.

Your patient was seen at the
[Clinic] walk-in
on _____
for the following reason...

patient label

☐ behavioural health consultation _____

☐ episodic care _____

If you would like more information related to this patient visit, please contact me at the number above.

PCN Behavioral Health Consultant
& Registered Nurse

Figure 10 – Sample Continuity of Care communication form

- The PCN keeps a very current and active online compendium of Local Resources on its website at www.palliserpcn.ca . This has become a “go-to” spot for many local organizations looking to provide coordinated and integrated health and social services for patients. There are currently 274 resources listed. The Local Resources section of the website has grown in use to account for 480 page views per month.

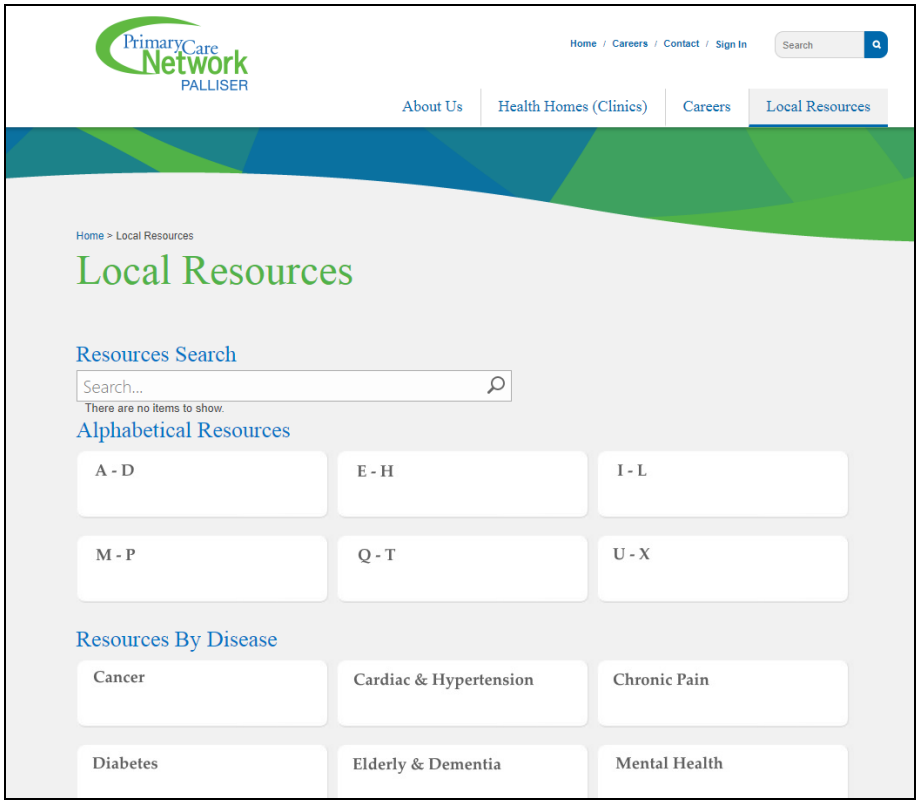
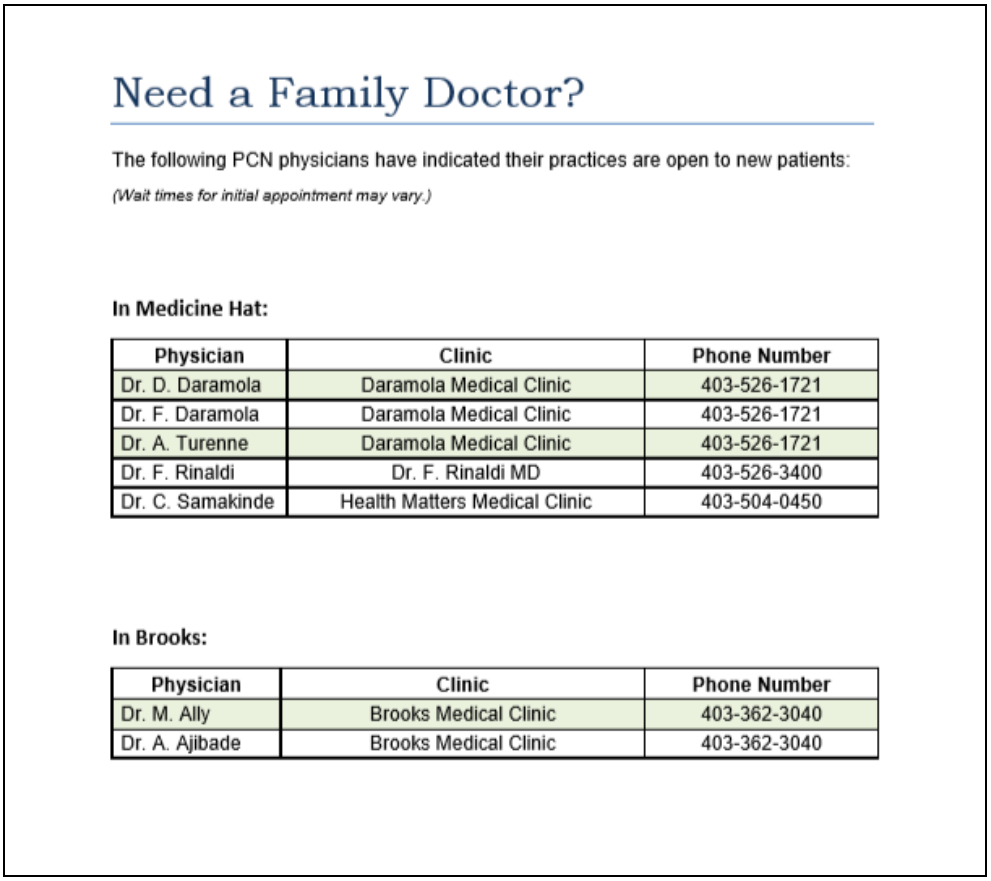


Figure 11 – Palliser PCN Website Local Resources Landing Page

- Where a patient receives service and does not identify a primary care physician the patient is provided a list of physicians accepting new patients. This list is updated monthly, distributed and available to patients. The Palliser PCN website homepage link listing this information has been updated monthly since 2015. Last year, there were 950 monthly patient visits to this homepage link. The listing is also distributed to:
    - emergency departments
    - walk-in clinics
    - Stabilization & Transition Clinic
    - 38 different community resources (email)
    - Alberta Find-A-Doc website administrators



Need a Family Doctor?

The following PCN physicians have indicated their practices are open to new patients:

(Wait times for initial appointment may vary.)

In Medicine Hat:

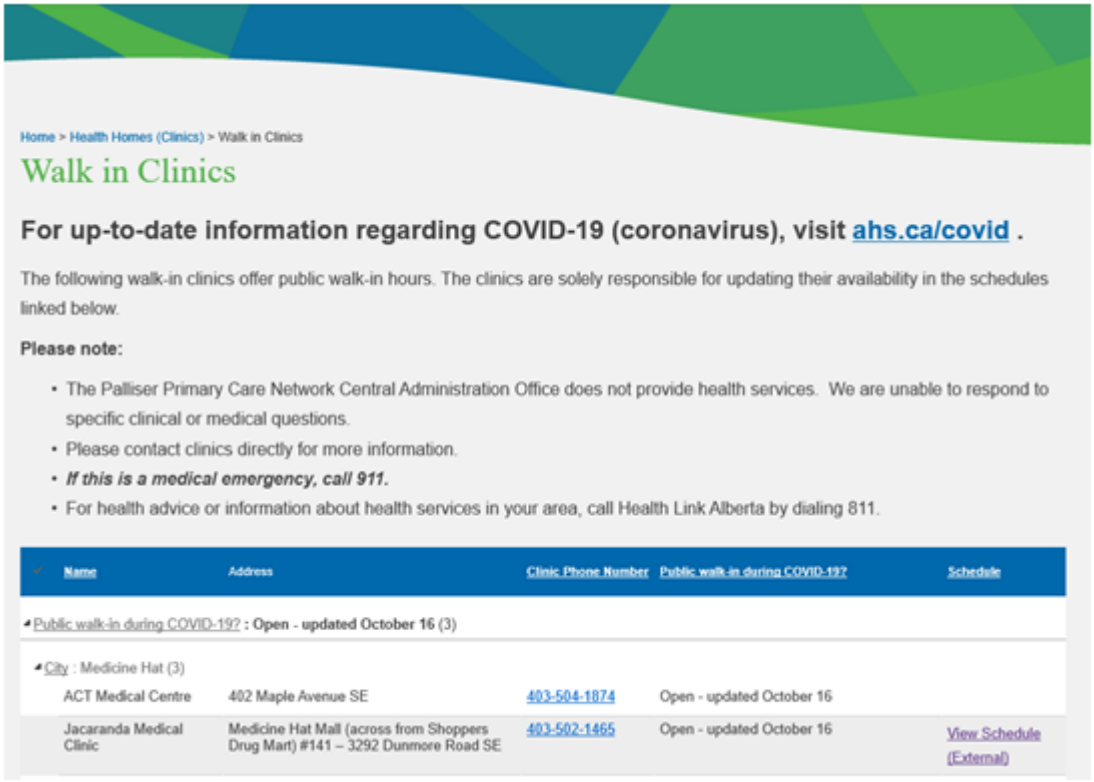
Physician	Clinic	Phone Number
Dr. D. Daramola	Daramola Medical Clinic	403-526-1721
Dr. F. Daramola	Daramola Medical Clinic	403-526-1721
Dr. A. Turenne	Daramola Medical Clinic	403-526-1721
Dr. F. Rinaldi	Dr. F. Rinaldi MD	403-526-3400
Dr. C. Samakinde	Health Matters Medical Clinic	403-504-0450

In Brooks:

Physician	Clinic	Phone Number
Dr. M. Ally	Brooks Medical Clinic	403-362-3040
Dr. A. Ajibade	Brooks Medical Clinic	403-362-3040

Figure 12 - PCN Need a Family Doctor Website Listing – revised October 20, 2020

- Since 2015, the PCN has assisted public walk-in clinics to be listed on the PCN website, including hosting their schedule if they agree to keep it up-to-date. Average monthly patient visits to PCN Website walk-in pages: 4,120.



Home > Health Homes (Clinics) > Walk in Clinics

Walk in Clinics

For up-to-date information regarding COVID-19 (coronavirus), visit ahs.ca/covid .

The following walk-in clinics offer public walk-in hours. The clinics are solely responsible for updating their availability in the schedules linked below.

Please note:

- The Palliser Primary Care Network Central Administration Office does not provide health services. We are unable to respond to specific clinical or medical questions.
- Please contact clinics directly for more information.
- ***If this is a medical emergency, call 911.***
- For health advice or information about health services in your area, call Health Link Alberta by dialing 811.

Name	Address	Clinic Phone Number	Public walk-in during COVID-19?	Schedule
Public walk-in during COVID-19? : **Open - updated October 16** (3)				
City : Medicine Hat (3)				
ACT Medical Centre	402 Maple Avenue SE	403-504-1874	Open - updated October 16	
Jacaranda Medical Clinic	Medicine Hat Mall (across from Shoppers Drug Mart) #141 – 3292 Dunmore Road SE	403-502-1465	Open - updated October 16	View Schedule (External)

Figure 13 – PCN Website Walk In Clinic Listing – revised October 20, 2020

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.

Community & Population Needs

Engagement

COMMUNITY MEETINGS

2019-2020

- Health Advisory
- Friends of Medicare Medicine Hat Not-for-Profit ED Group
- Local Immigrant Partnership
- Elder Abuse Committee
- Medical Issues Committee Brooks
- Medicine Hat Family Practice
- Sexually Transmitted Blood Borne Infection Working Group
- Safe Community Association
- Rural/Remote Access Working Group Digestive Health (SCN)
- PCN Evaluation Task Group
- PCN Community Working Group
- Find a Doctor Working Group
- Opioid Response & Harm Reduction Steering Committee
- South Zone Chronic Pain Program Diabetes, Obesity & Nutrition SCN
- Community Collaboration Network(MH Brooks)
- Community Transitions for Children's Mental Health Working Group (Brooks)
- SZ Chief Zone Officer Management Meeting

MARKETING & PATIENT EDUCATION

EVENTS

Service Planning

EVIDENCE REVIEW

> *"PCN provider is a must for all Doctor clinics. Very knowledgeable and helpful. Always pleasant."*
>
> Patient Survey 2019

SOUTH ZONE PCN COMMITTEE

- *Service Plan*

Patient Survey 2019

"Since moving to Alberta, the PCN providers have provided excellent service. A great program we should share with other provinces."

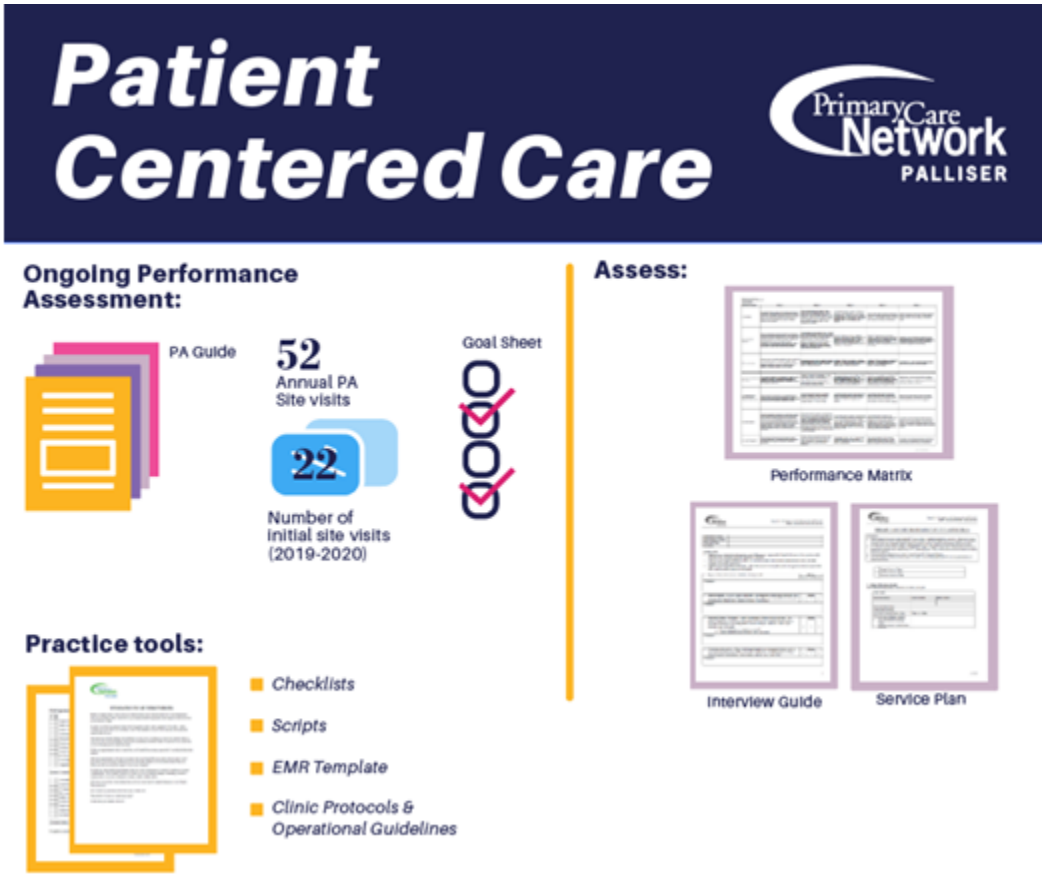
"All clinics must always have PCN's. They are as great as doctors."

"I have complete confidence in my care. I can't believe how much knowledge and care my nurse gives. Makes me want to try harder. She doesn't judge my bad habits but gives positives to why to change."

Overall satisfaction with the care received

4. **Patient's Medical Home:** Implement patient's medical home to ensure Albertans have access to the right services through the establishment of interdisciplinary teams that provide comprehensive primary care.


PCN Staffing
Primary Care Network PALLISER
49.21
Total FTE (clinical)
80
Total employees at the PCN
72
Total clinical staff employed by PCN
51
Registered Nurses
2
RD
10
Behavioral Health Consultants
12
Central Office Staff
3
Nurse Practitioners


Patient Centered Care
Primary Care Network PALLISER
Ongoing Performance Assessment:
PA Guide
52
Annual PA Site visits
22
Number of initial site visits (2019-2020)
Goal Sheet
Practice tools:
Checklists
Scripts
EMR Template
Clinic Protocols & Operational Guidelines
Assess:
Performance Matrix
Interview Guide
Service Plan

Education

Primary Care Network PALLISER

Orientation classes resumed in June 2020, allowing up to 10 attendees per class

85%

Overall Satisfaction for 2020 workshops

PCN Workshops Budget:

- March 2021
- February 2021
- January 2021
- November 2020
- October 2020
- September 2020
- August 2020

4 workshops from March–November 2020

Virtual and in-person learning sessions

Different use of technologies, real time communication between Brooks and Medicine Hat through live audio and video conference solutions

Upcoming workshops:

January - Compelling Change
February - Respiratory
March - QI

74 Attendees for the "Closing the Loop" workshop

7 PCN Physicians attended the workshops on average

60 Attendees for the "Beyond the MOCA" workshop

60 Attendees for the "Hot Topic - Women's Health" workshop

84%

Of participants stated that the subject matter will have an impact on their clinical

Table 2.1: Changes to Priority Initiatives and Elements Over-Time

Priority Initiatives and Elements in 2017-2020 Business Plan	Priority Initiatives and Elements **Added (A)** since 2017-2020 Business Plan or **Enhanced (E)** for Renewal 2021-2024	Priority Initiatives and Elements in 2017-2020 Business Plan **Discontinued** for Renewal 2021-2024	**New** Priority Initiatives and Elements for Business Plan Renewal 2021-2024
PROFESSIONAL SUPPORT IN HEALTH HOMES (addition of RNs / Other Professionals to Physician Offices)	For 2021-2024, the PCN will enhance its professional support in Health Homes by optimizing the supervision and education of these employees both clinically and in Health Home transformation knowledge and skills. Inclusive in this initiative will be nursing staff in the communities of Medicine Hat and Brooks specially trained to support family physicians in the provision of low-risk obstetrical care.		
OBSTETRICS (this includes: In partnership with AHS, the PCN will support family obstetric services in Medicine Hat and Brooks)		Based on population health needs data, the 4 objectives set by Alberta Health (Accountable & Effective Governance, Strong Partnerships & Transitions of Care, Health Needs of the Community and Population, Patient's Medical Home), and the PCN Board Priorities (Physician and team awareness and engagement, clinic improvements, staff retention, physician wellness and pride) this Priority Initiative will be discontinued in the 2021 – 2024 Business Plan. There is a risk of public unrest related to discontinuation of this program. Service efficiency may change dependent on individual clinic efficiency. Provider competence could change if service become decentralized. Physician recruitment could be impacted.	
MEASUREMENT AND PRACTICE IMPROVEMENT (this includes: Panel Identification and management, EMR optimization, practice improvement methodologies, development and support of clinic practice improvement teams. Also includes PCN administration and governance measurement & improvement.			

3. Zone PCN Service Plan and Priority Initiatives

The PCN recognizes the significant work completed by the South Zone PCN Committee, which developed their Service Plan by completing a thorough analysis of the health needs of the population, health care utilization data, stakeholder feedback, the inventory of current services, evidence from the literature and then developed a process for evaluation. Subsequently, the two identified Zone Priority populations, Complex Patients and Addictions and Mental Health Patients, have been incorporated into the PCN's Priority Initiatives. Further, the overarching four priority areas outlined in the Zone Service Plan are integrated into the PCN's Priority Initiatives. These priority areas include:

1. Continuity of Care: Supporting relational, informational, and management continuity.
2. Building Capacity: Identifying and understanding existing promising practice. Facilitate education and support implementation of promising practice.
3. Quality Improvement: Encourage practice improvement in the Patient's Medical Home (PMH) to support patients with transition, prevention and management of addiction and mental health.
4. Integration: Facilitate identification and understanding of best practices approaches while spreading promising practice tools and models.

The PCN supports all objectives and priorities of the PCN Governance Framework. The PCN's Chair and the Physician Group NPC Vice-Chair are voting members of the South Zone PCN Committee. The PCN's Executive Director and the Physician Group NPC Non-Voting member are non-voting members of the South Zone PCN Committee. The PCN's Community Director is also a member of the South Zone PCN Committee.

The PCN actively contributes to the implementation of the Zone PCN Service Plan. The PCN's Executive Director serves as the Co-Chair of the South Zone PCN Service Plan Implementation Steering Committee, and actively supports the development, implementation and monitoring of the Service Plan, including alignment with Chinook PCN, were possible and appropriate.

The Zone Priorities have been integrated into the Palliser PCN objectives of optimizing Professional Support within the Health Homes as well as Measurement and Practice improvement towards transforming physician clinics into Health Homes, supporting strong partnerships & transitions of care, and supporting the data driven needs of the community and population.

3.1. Summary of Comparative Information by Provincial Objective

Provincial Objective	Priority Initiatives	Alignment to Zone PCN Service Plan Priorities and Strategic Objectives	Key Elements	Service Responsibilities Addressed
1. Accountable & Effective Governance - Establish clear & effective governance roles, structures & processes that support shared accountability & the evolution of primary healthcare delivery.		Participation in South Zone Primary Care Network Committee and South PCN Committee – Implementation Steering Committee supports this work.	• Maintain and update a Board Manual and offer annual board orientation for new board members. • Include board development items as part of regular board agendas. • Host an annual board retreat. • Assess the Executive Director. Engage in ongoing improvement to ensure this process includes formative as well as summative components. • Engage in board assessment. Participate in the HSO process which includes individual Board member assessment. Assess each board meeting.	
	Measurement & Practice Improvement		The Board participates in various board measurement activities. These are reviewed on a quarterly basis and provide foundational information for the annual board retreat and action planning.	

Provincial Objective	Priority Initiatives	Alignment to Zone PCN Service Plan Priorities and Strategic Objectives	Key Elements	Service Responsibilities Addressed
2. Strong Partnerships & Transitions Of Care - Coordinate, integrate & collaborate with health services & other social services across the continuum of care.	Professional Support In Health Homes	**SZPCNC Service Plan Goal 1:** Facilitate increased understanding of the value of relational continuity to the Patient's Medical Home with patients and providers through the use of zonal communication and processes. **SZPCNC Service Plan Goal 2:** Facilitate the implementation of informational and management continuity strategies within member organizations in the South Zone by using zonal patient flow committee structure to bring awareness and change. **SZPCNC Service Plan Goal 8:** Spread promising practice tools and models across the South Zone through the development and implementation of a patient centered integration plan based on the priority populations.	• The existing physician office (including after-hours service), ER and Healthlink resources provide appropriate 24-hour management of access. • Shared health record within physician clinic. • Community Resources Web service • Community Resource Expo • AHS and Community NPCs partnering via workshops, staff meetings, online discussion board and face-to-face front line provider interactions. • Linkages with existing zone programs. • PCN networking and linkage opportunities with secondary, tertiary, and long-term care services. • Participation on various AHS committees including patient flow and H2H2H.	(15) Information mgt. (16) Population health (17) 24/7 mgt of access (18) Lab and D/I access (19) Coordination with Regional Svcs

Provincial Objective	Priority Initiatives	Alignment to Zone PCN Service Plan Priorities and Strategic Objectives	Key Elements	Service Responsibilities Addressed
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.	Professional Support In Health Homes	**SZPCNC Service Plan Goal 3:** Increase adoption of promising practice in the South Zone by capturing existing promising practice related to our priority populations and supporting awareness and implementation. **SZPCNC Service Plan Goal 5:** Improve care to patients with substance use disorder by collaborating and coordinating with member organizations and community partners in the South Zone on the implementation of promising practice.	• Participate in not-for-profit executive director meetings. • Engage with Zone PCN Committee. • Utilize high level data sets when and where appropriate. • Engage with community groups when invited (e.g. Health Advisory Council, Friends of Medicare). • Optimize standardization and utilization of EMR data where appropriate.	Basic ambulatory care (2) Complex care (3) Psychological counseling (4) Chronic screening/ prevention (5) Family planning (6) Well-child care (7) Obstetrical care (8) Palliative care (9) Geriatric care (10) Chronic care (11) Minor surgery (12) Minor emergency (13) Primary inpatient (14) Rehabilitative care (15) Information mgt (16) Population health (17) 24/7 mgt of access (18) Lab + D/I access (19) Coordination with regional services (20) Unattached patients
4. Patient's Medical Home - Implement patient's medical home to ensure Albertans have access to the right services through the establishment of interdisciplinary teams that provide comprehensive primary care.	Professional Support In Health Homes	**SZPCNC Service Plan Goal 4:** Facilitate the adoption of promising practice related to the priority populations across the South Zone through the development of educational resources and supports. **SZPCNC Service Plan Goal 6:** Support practice improvement in the Patient's Medical Home aimed at the prevention of substance use disorder and improved care for patients with complex and mental health conditions through collaborating with PCNs.	• Addition of RNs / Other Professionals to Physician Offices • Increase the emphasis on health promotion, disease and injury prevention, care of the medically complex patient, and care of patients with chronic disease. • PCN professional staff training.	(2) Complex Care (3) Psychological Counselling (4) Chronic screening/ prevention (5) Family planning (6) Well-child care (7) Obstetrical care (9) Geriatric care (10) Chronic care (14) Rehabilitative care

Provincial Objective	Priority Initiatives	Alignment to Zone PCN Service Plan Priorities and Strategic Objectives	Key Elements	Service Responsibilities Addressed
	Measurement & Practice Improvement	**SZPCNC Service Plan Goal 7:** Identify and support the implementation of promising practice approaches to integration through utilization of current resources and supports available to the South Zone.	• Office Practice Redesign including: ▸ Panel identification & management ▸ Form and support Health Home teams and implement practice improvement methodologies including panel identification and management • EMR optimization	(1) Basic ambulatory care (17) 24/7 mgt of access (20) Unattached patients

3.2. Priority Initiatives: PROFESSIONAL SUPPORT IN HEALTH HOMES

1. Impact of the PCN on this Initiative during its 2006-2021 Business Plans

The PCN has experienced success in implementing Professional Support in Health Homes. Most participating physicians have multi-disciplinary teams working in their respective clinics. These teams share the electronic medical record, care plans, and have the opportunity for frequent informal discussion resulting in improved:

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

2. Service Gaps:

- Coordination of the delivery of disease treatment (acute care) and follow-up (primary care);
- Appropriate access to community support programs;
- Communication and "patient health sharing" among relevant care providers throughout the health care system;
- Need for navigation and assistance through rapidly changing community supports and referrals;
  Care providers in each of their specific areas may provide the best programming available but lack of coordination between disciplines and inappropriate access to supports reduces the effectiveness of the care program.

3. Objectives:

Each physician / clinic will implement a detailed primary care network service plan focusing on the delivery of improved care to clinic patients. The resources available from the PCN are insufficient for each physician to manage all problems and therefore physicians will concentrate on those diseases (most significant incidence rates) and other issues that are most applicable to their patients.

Improvement of service delivery will include:

- Improve interdisciplinary team practice
- Improve interdisciplinary care planning
- Improve appropriate access for patients
- Enhance linkages with other health care providers
- Enhance consistency of treatment
- Provide coordinated, seamless care for medically complex patients
- Improve patient self-management of chronic disease
- Improve patient and physician satisfaction with appropriate access to and quality of primary health care services.

The PCN employees will deliver comprehensive disease management services, focusing on the following services to patients:

- Chronic Disease Management: Hypertension & other cardiovascular disease (CHF, atrial fibrillation, peripheral artery disease), blood pressure management, diabetes, dyslipidemia, obesity, COPD/asthma, chronic digestive disorders (celiac disease), chronic pain (bone and joint), and osteoporosis.
- Disease Screening: Metabolic syndrome, dyslipidemia, diabetes, kidney disease, anemia, thyroid, dementia, depression, alcohol, smoking and illicit drug use, hearing and vision investigation.
- Disease Prevention: Education on smoking cessation, immunization, healthy nutrition and exercise.
- Health Maintenance: Immunizations, socioeconomic issues as they pertain to medication and health aids, palliative and end of life care.

4. Target Population:

Within the Palliser PCN, individual participating physicians determine the area of disease that they will concentrate on within their offices, based on the needs presenting within their patient population.

Element	Zone PCN Service Plan Priority Initiative	Description	Resource Requirements
Addition of RNs / Other Professionals to Physician Offices	**SZPCNC Service Plan Goal 4:** Facilitate the adoption of promising practice related to the priority populations across the South Zone through the development of educational resources and supports. **SZPCNC Service Plan Goal 5:** Improve care to patients with substance use disorder by collaborating and coordinating with member organizations and community partners in the South Zone on the implementation of promising practice. **SZPCNC Service Plan Goal 6:** Support practice improvement in the Patient's Medical Home aimed at the prevention of substance use disorder and improved care for patients with complex and mental health conditions through collaborating with PCNs.	**Purpose:** Develop interdisciplinary family practice teams/programs to support family practice physicians in the delivery of services to patients. **Roles:** Teams will be led by physicians. Individual team composition will include RNs/other professionals based on the physician's primary care network service plan. **Model:** The RN/other professional will be located within the physicians' clinics and will normally deliver services on an appointment basis to patients (initially focusing on chronic disease patients). Patients will normally be assessed by the RN/other professional in an initial appointment of 55 minute average (range of 25-90 minutes) and then receive follow-up appointments of 35 minute average (range of 20-65 minutes) where required. The RN/other professional will have space dedicated to their needs. The PCN employees will also access clinic phones, reception support and minor office supplies. Group education and medical visits may also be offered (where deemed appropriate by the clinic/PCN). **Linkages:** Teams will work collaboratively with zonal and provincial programs to support and facilitate development of strategies and programs for disease screening, prevention, and management in those areas identified by the clinic in their approved primary care network service plan.	• Annual supervision / program planning will be compensated at the rate of $4,030* per FTE per year). The stipends are calculated based on the estimated number of physician hours compensated at the expected AH approved rate. (currently $221/hr). Total over 3 years **$624k**. • The physician will be compensated for rental / clinic supports such as: EMR remote access for evaluation/measurement; PCN employee access to clinic phones, reception support, medical consumables, office overhead (proportionately) and minor office supplies. The stipend of $3290* per FTE per year is calculated based on the estimated dedicated physical space (80 square feet) multiplied by compensation for rental/clinic supports at the estimated market rate of $41.13 per square foot per annum. The market rate is based on the average lease and other support costs for clinics within the PCN area. Total over 3 years **$507k**. • The PCN provides approximately 4 workshops per year, covering clinical and health home educational topics for staff and physicians. The PCN strongly encourages physicians to attend the health home topics and provides stipends for physician attendance. An educational workshop may have clinical plus health home components. Generally, each physician will be eligible for stipends for one workshop per year. Physicians will be paid for session attendance, to a max. of 7.5 hours per session, at the AH approved hourly rate of $221/hr. A maximum of $40k per year will be paid for this program. Total over 3 years **$ 120k.** • Physicians may access from 0.5 FTE to 1.0 FTE RN/Other Health Professional (FTE = 1950 hours/annum) depending on physician panel size. The range of FTE is determined by the PCN Board based on budget resources available. A maximum of 51.5* FTEs are expected to be engaged each year over the course of the business plan.

Access: Appropriate access will be for patients identified in the clinic specific approved primary care network service plan. Appropriate access may occur during some evenings and weekend dependent upon the schedules of individual team members. As patients followed by the PCN Professional should now take less of the physician's time, the physician may be able to accommodate his/her current patients in a more timely way and may be able to address some unattached patients.

Development and Implementation: This program is ongoing in its implementation and further optimization.

Direct Care Provider staffing (salaries plus benefits):

Licensed Providers		Yr 1	Yr 2	Yr 3	Term total
RN	FTE	39.95	39.95	39.95	
Annual ($k/yr)		$91.2	$91.2	$91.2	
Total ($k)		$3,643	$3,643	$3,643	**$10,929**
RN - Educator	FTE	1.00	1.00	1.00	
Annual ($k/yr)		$98.0	$98.0	$98.0	
Total ($k)		$98	$98	$98	**$294**
BHC	FTE	9.00	9.00	9.00	
Annual ($k/yr)		$95.0	$95.0	$95.0	
Total ($k)		$855	$855	$855	**$2,565**
Dietitian	FTE	0.90	0.90	0.90	
Annual ($k/yr)		$95.0	$95.0	$95.0	
Total ($k)		$86	$86	$86	**$258**
NP	FTE	1.65	1.65	1.65	
Annual ($k/yr)		$125.0	$125.0	$125.0	
Total ($k)		$206	$206	$206	**$618**

The above estimates assume 1950 hrs/FTE and includes 11% benefits.

- The PCN also cover costs for PCN staff to be incorporated into the physician clinics, specifically: RN/OHP education & training (**$180k**), Staff travel (compensated at $0.505, medical & IT equipment and other supplies (**$255k**).
- The total expenditure for this initiative over the three year business plan is estimated at $16.350 million and will be entirely funded from per capita grant funding.

**** These represent maximum funding amounts that would be provided. The PCN Board, as part of its annual budget deliberations and reflective of the funding available and financial priorities of the PCN, may reduce these funding amounts in future years.***

Risks & Mitigating Activities Associated with PROFESSIONAL SUPPORT IN HEALTH HOMES Priority Initiatives including the programming your PCN offers in support of a Zone Service Plan Priority Initiative.

Description of Risk	Zone PCN Service Plan Priority Initiative	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Scope of Practice: Health care providers exceeding scope of practice and/or individual competence in providing care.		• Ongoing RN/other professional learning needs assessment and annual performance assessment. • Ongoing PCN wide educational workshops and individual education, mentoring, training as required. • Ongoing assessment of RN/other professional role and competency. • In-clinic clinical supervision, assessment and ongoing learning plans. • Collaborating with appropriate licensing body in competency assessment. • Maintenance and adherence to appropriate job descriptions.	• Address RN/other professional and/or physician learning needs. • Ensure appropriate insurance coverage.
Team Development: Physicians and RN/other professional will have varying skills in working in a multi-disciplinary team.		• During the service plan stage physicians will be provided strategies to maximize team development. • During the interview process the physician and potential employee will be facilitated to discuss team roles and expectations. • RN/other professional will receive ongoing education and mentorship to integrate into the office team. This education may be offered to physicians as well. • PCN Facilitator is available to assist clinic teams in clinic specific team development.	• The PCN will assist the physician, RN/other professional, and office team members to collaboratively solve team development issues as required.
Space: The RN/Other Health Professional will need to be co-located within the physician clinic and will usually require a dedicated office space. The physician may need to renovate in order to accommodate the additional PCN employee(s).		• The PCN will work with physicians/clinics to explore viable options to deal with space issues.	• The program will need to be scaled up and/or down dependent on space available.

3.3. Priority Initiative: MEASUREMENT AND PRACTICE IMPROVEMENT

1. Impact of the PCN on this Initiative during its 2009-2021 Business Plans

25 clinics have concluded practice improvement learning sessions. As well, some clinics that have not been able to participate in the learning sessions are accessing the Practice Improvement Facilitators for support in commencing and/or maintaining improvement efforts.

- *Access: Attached Patients:* For clinics who have participated in the learning sessions there have been improvements in the third next available appointment. The PCN will continue to encourage all participating physicians to submit TNA to the PCN along with the PCN clinical employees. Clinics are encouraged to engage in ongoing real-time panel verifying. Where patients seek service outside of their Health Home PCN employees send a brief 'report' to the patient identified family physician.
- *Access: Unattached Patients:* Several participating clinics report an increase in acceptance of new patients. At the time of writing the business plan (November 2020), there are 2 physicians in Brooks and 5 physicians in Medicine Hat), accepting new patients.
- *Access: Appropriate Primary Care Services:* All health professionals in the PCN are assisted by a Clinical Supervisor and a Practice Improvement Facilitators to assist with working to their full scope of practice and consequently being able to see patients who may have otherwise utilized physician time.
- *Health Promotion, Disease and Injury Prevention:* All clinics have access to the Practice Improvement Facilitators and PCN Analyst to assist them with utilizing their EMR more fully to identify patients appropriate for screening, surveillance, diagnosis and management.
- *Linkages:* Practice Improvement Facilitators support clinics to develop and implement communication agreements with AHS services, medical specialist care and community resource linkages resulting in strengthened and more streamlined relationships throughout the system.
- *Multi-disciplinary Team Development:* The Practice Improvement Facilitators and Clinical Supervisors support practice teams towards Patient's Medical Home Optimization including efforts to improve communication, cohesiveness and awareness of the need to ensure effective and efficient use of existing resources within the team. PCN supports clinics in ongoing team development through both PCN wide workshops and in-clinic specific learning opportunities.
- *EMR Optimization:* The Practice Improvement Facilitators and Analyst support clinic practice teams to improve utilization of their EMRs and increase their awareness of the need to integrate the EMR in all aspects of the Health Home, including panel identification and management. The PCN strives to assist clinics in maximizing their EMR through standardization of their day-to-day clinical use of the EMR rather than engaging in panel verifying and screening as outside the clinical visit activities.

2. Service Gaps:

Much work remains to be done in this area. Although there have been improvements, many teams are just gaining momentum in this area. Efficient and effective use of electronic medical records will assist teams to track their patients and provide objective data related to their patients' identified needs. As well, clinics will be able to measure the effect their efforts towards office practice improvement are having.

3. Objectives

- Improve appropriate access, optimize Health Home teams and implement decision support tools.

4. Target Population:

- 100% of patients of PCN physicians.

5. Measurement and Practice Improvement – Elements:

<table>
<tr><th>Element</th><th>Zone PCN Service Plan Priority Initiative</th><th>Description</th><th>Resource Requirements</th></tr>
<tr>
<td>Form and support Health Home teams and implement practice improvement methodologies including panel identification and management</td>
<td>SZPCNC Service Plan Goal 3: Increase adoption of promising practice in the South Zone by capturing existing promising practice related to our priority populations and supporting awareness and implementation.

SZPCNC Service Plan Goal 8: Spread promising practice tools and models across the South Zone through the development and implementation of a patient centered integration plan based on the priority populations.</td>
<td><u>Purpose:</u> Implement the concepts of clinical office practice redesign to optimize clinic resources and processes, to increase appropriate access, improve patient outcomes and increase patient and provider satisfaction. Physician enrolment is voluntary.

<u>Roles:</u> Within the clinic, the Health Home team will consist of the physician, clinic staff (office manager, assistants, and receptionists) and a PCN professional team member (e.g. PCN RN). A centrally located team will support the team through periodic in-clinic and remote work. This team includes a Patient's Medical Home Optimization Manager, Practice Improvement Facilitators, and an Analyst.

<u>Model:</u> Health Home teams will be located within physician practices. Health Home teams will have access to PCN Practice Improvement facilitators and the Analyst to support their measurement and improvement efforts.

<u>Linkages:</u> The PCN will work closely with SZPCN Committee and AHS programs to provide best practice process information, so that efficiencies may be gained throughout the referral system. There may be opportunity to collaborate with the Alberta Medical Association ACTT team and the AHS Strategic Clinical Networks.

<u>Access:</u> The Measurement and Practice Improvement initiative will be of indirect benefit to 100% of patients of PCN physicians and of direct application to all physician clinic teams supporting these patients.

<u>Development and Implementation:</u> For 2021 to 2024, the focus will be on further development and optimization of the Health Home. This will include clinic team development, ongoing EMR optimization, identifying and optimizing clinic efficiencies and clinic linkages with specialists and the community.</td>
<td>

An average of 6.0* FTEs are expected to be engaged each year over the course of the business plan.

M&PI staffing (salaries plus benefits):
<table>
<tr><th></th><th></th><th>Yr 1</th><th>Yr 2</th><th>Yr 3</th><th>Term total</th></tr>
<tr><td>Facilitators, Analysts, & Assistant</td><td>FTE</td><td>6.00</td><td>6.00</td><td>6.00</td><td></td></tr>
<tr><td>Annual ($k/yr)</td><td></td><td>$83.2</td><td>$83.2</td><td>$83.2</td><td></td></tr>
<tr><td>Total ($k)</td><td></td><td>$499</td><td>$499</td><td>$499</td><td>$1,497</td></tr>
</table>
The above estimates assume 2023 hrs/FTE and includes 11% benefits.

These staff will incur some travel and supplies costs (total over 3 years $45k).
The total expenditure for this initiative over the three year business plan is estimated at $1,542k.

</td>
</tr>
</table>

** These represent maximum funding amounts that would be provided. The PCN Board, as part of its annual budget deliberations and reflective of the funding available and financial priorities of the PCN, may reduce these funding amounts in future years.*

6. Practice Improvement - Risks & Mitigating Activities:

Description of Risk	Zone PCN Service Plan Priority Initiative	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Measurement and Facilitation and Evaluation Support: The demand for analyst and facilitator support may be greater than the resources available. Clinics may not wish to engage in Health Home optimization work (e.g. panel verifying).		• Build capacity within the clinic to manage their own data analysis and practice improvement. • Ensure clinics are aware of the limited support capacity available. • The PCN will maximize the use of the 5 A's to work with clinics in a motivating, meaningful and long-lasting manner.	• A priority setting system will be developed to ensure that the resources available provide the greatest benefit to clinics and patients. • A priority setting system will be used to focus PCN attention on clinics who need additional change management support.

3.4. Implementation Timeline

Time Period	Key Activities	Deadlines, Goals & Comments
April 1 to Sept 30, 2021	• **Professional Support in Health Homes:** Improve the knowledge, skill and competency of family practice teams providing comprehensive chronic disease management.	• PCN education and training workshops will be held locally (PCN staff will attend as well as some physicians). • Comprehensive RN/OHP performance assessment and improvement plan.
	• **Measurement and Practice Improvement:** Develop clinic capacity to create individualized improvement plans and accompanying measurement skills.	• This will be an ongoing activity as clinics engage in this process.
	• **Reporting**: Develop/submit annual report for prior fiscal year.	• Submission deadline of July 1, 2021
Oct 1, 2021 to March 31, 2022	• **Professional Support in Health Homes:** Improve the knowledge, skill and competency of family practice teams providing comprehensive chronic disease management.	• PCN education and training workshops will be held locally. • Comprehensive RN/OHP performance assessment and improvement plan.
	• **Measurement and Practice Improvement:** Develop clinic capacity to create individualized improvement plans and accompanying measurement skills.	• This will be an ongoing activity as clinics engage in this process.
	• **Reporting**: ♦ Develop and submit mid-year report. ♦ Develop and submit budget for fiscal 2022/2023 (April 2022 to March 2023).	• Submission deadline of Oct 31, 2021 • Submission deadline of Feb 1, 2022
April 1 to Sept 30, 2022	• **Professional Support in Health Homes:** Improve the knowledge, skill and competency of family practice teams providing comprehensive chronic disease management.	• A PCN education and training workshops will be held locally. • Comprehensive RN/OHP performance assessment and improvement plan.
	• **Measurement and Practice Improvement:** Develop clinic capacity to create individualized improvement plans and accompanying measurement skills.	• This will be an ongoing activity as clinics engage in this process.
	• **Reporting**: Develop/submit annual report for prior fiscal year.	• Submission deadline of July 1, 2022
Oct 1, 2022 to March 31, 2023	• **Professional Support in Health Homes:** Improve the knowledge, skill and competency of family practice teams providing comprehensive chronic disease management.	• A PCN education and training workshops will be held locally. • Comprehensive RN/OHP performance assessment and improvement plan.
	• **Measurement and Practice Improvement:** Develop clinic capacity to create individualized improvement plans and accompanying measurement skills.	• Measurement and Practice Improvement booster workshop will be held locally.

Time Period	Key Activities	Deadlines, Goals & Comments
	• **Reporting**: ♦ Develop and submit mid-year report. ♦ Develop and submit budget for fiscal 2023/2024 (April 2023 to March 2024).	• Submission deadline of Oct 31, 2022 • Submission deadline of Feb 1, 2023
April 1 to Sept 30, 2023	• **Professional Support in Health Homes:** Improve the knowledge, skill and competency of family practice teams providing comprehensive chronic disease management.	• A PCN education and training workshops will be held locally. • Comprehensive RN/OHP performance assessment and improvement plan.
	• **Measurement and Practice Improvement:** Develop clinic capacity to create individualized improvement plans and accompanying measurement skills.	• This will be an ongoing activity as clinics engage in this process.
	• **Reporting**: ♦ Develop/submit annual report for prior fiscal year. ♦ Begin plan for business plan renewal, engage stakeholders in business plan.	• Submission deadline of July 1, 2023 • Use PCN internal timeline process.
Oct 1, 2023 to March 31, 2024	• **Professional Support in Health Homes:** Improve the knowledge, skill and competency of family practice teams providing comprehensive chronic disease management.	• A PCN education and training workshops will be held locally. • Comprehensive RN/OHP performance assessment and improvement plan.
	• **Measurement and Practice Improvement:** Develop clinic capacity to create individualized improvement plans and accompanying measurement skills.	• Measurement and Practice Improvement booster workshop will be held locally.
	• **Reporting**: ♦ Develop and submit mid-year report. ♦ Develop and submit budget for fiscal 2024/2025 (April 2024 to March 2025). ♦ Complete and submit business plan.	• Submission deadline of Oct 31, 2023 • Submission deadline of Feb 1, 2024 • Submit drafts to PCN Board, physician membership, and PCN Zone Committee for feedback. • Submit final draft to PCN Board for approval to submit to AH via timelines provided.

4. Financial Plan

1. Accountability:

The PCN will:

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

2. Financial Management and Disbursement of Primary Care Network Funds

Creation of financial policies:

- The PCN adheres to financial policies that are consistent with best practices.

Authorization of expenditures and Approval of payments:

- All expenditures conform to AH guidelines and adhere to the PCN business plan.
- Expenditures normally are approved by the PCN Executive Director (as designated by the PCN Board). Expenditures can also be approved by a combination of the Physician and AHS leads (or designates).

Recording disbursements:

- Disbursements are recorded in the PCN books in accordance with GAAP.

3. Accounting Services and Banking Information

The PCN operates its own independent accounting and banking processes. Monthly financial reports are prepared by PCN administration, reviewed by an external accountant and presented to the PCN Board. Annual financial statements are prepared by PCN administration and audited by independent external auditors.

4.1. PCN Budget Summary

Table 4.1A

Financial Plan Summary				
in thousands of dollars with one decimal place				
	Apr 1, 2021 to Mar 31, 2022	Apr 1, 2022 to Mar 31, 2023	Apr 1, 2023 to Mar 31, 2024	**Full Term**
Revenue:				
Per Capita funding (at $62/yr)	6,613.0	6,613.0	6,613.0	19,839.0
Nurse Practitioner Funding	206.0	206.0	206.0	618.0
Interest and Investment Income	10.0	10.0	10.0	30.0
Revenue Total	6,829.0	6,829.0	6,829.0	20,487.0
Expenses:				
Professional Support Within Health Homes	5,450.0	5,450.0	5,450.0	16,350.0
Measurement & Practice Improvement	514.0	514.0	514.0	1,542.0
Central Allocations	865.0	865.0	865.0	2,595.0
Expense Total	6,829.0	6,829.0	6,829.0	20,487.0
Excess of Expenses over Revenue (deficit)	**0.0**	**0.0**	**0.0**	**0.0**
Additional Cash Outlays - Capital asset purchases	**0.0**	**0.0**	**0.0**	**0.0**

Supplementary Table 4.1A.1: Summary of all budgeted capital asset purchases and amortization				
in thousands of dollars with one decimal place				
	Apr 1, 2021 to Mar 31, 2022	Apr 1, 2022 to Mar 31, 2023	Apr 1, 2023 to Mar 31, 2024	**Full Term**
1) Capital asset purchases during year	0.0	0.0	0.0	0.0
2) Amortization expense	0.0	0.0	0.0	0.0

Table 4.1B

Expense Estimates by Major Categories for Full Term of Business Plan

Planned Expenses (April 1, 2021 to March 31, 2024) **by Payment Type** (in thousands of dollars with one decimal place)

Payments to Physicians		Payments to AHS		Non-Phys. Direct Care Providers		Other Expenses		%	3 Year Totals
Professional Support Within Health Homes									
Administrative:				Registered Nurses	$10,929.0	RNs / OHCP: Education, training & orientation	$180.0		
Supervision/ program planning stipend	$624.0			Behavioral Health	$2,565.0	RNs / OHCP: Travel, medical & IT equipment, and other supplies.	$255.0		
Other:				Dietitians	$258.0	RN - Educator	$294.0		
Facilitators, Analysts, & Assistant	$507.0			Nurse Practitioners	$618.0				
Facilitators, Analysts, & Assistant	$120.0								
Health Homes Total	**$1,251.0**		**$0.0**		**$14,370.0**		**$729.0**	**79.8%**	**$16,350.0**
Measurement & Practice Improvement:									
						Facilitators, Analysts, & Assistant	$1,497.0		
						Travel, supplies & other expenses	$45.0		
PI Total	**$0.0**		**$0.0**		**$0.0**		**$1,542.0**	**7.5%**	**$1,542.0**
Central Allocations (not specific to a particular initiative):									
Administrative:						Staffing	$1,866.0		
Board Stipends	$180.0					Professional Svcs (Accting, Audit, HR, Legal)	$210.0		
						Central Office (Rent, Utilities & Related Costs)	$210.0		
						Insurance (Directors, Liability)	$45.0		
						Miscellaneous (office supplies, etc)	$84.0		
Central Total	**$180.0**		**$0.0**		**$0.0**		**$2,415.0**	**12.7%**	**$2,595.0**
Budget Estimate Totals by Category	**$1,431.0**	0%	**$0.0**	70%	**$14,370.0**	23%	**$4,686.0**	**100%**	**$20,487.0**

Memo: Breakdown of Payments to Physicians

Clinical	0.0	(direct patient care + interaction with team members that is related to specific patients/families, etc)
Administrative	804.0	(governance and mgt for PCN/NPC, initiative mgt, program development, etc.)
Other	627.0	(education/training, cost recovery, etc.)
Total	**$1,431.0**	
	7%	-

4.2. Assumptions

General Financial Assumptions:

- Revenue: Revenue is calculated based on the most recent population numbers at the current AH rate per capita. The PCN expects negligible growth over the course of the business plan.
- Payment Rates to Physicians: Payment rates for non-insured services are determined based on the current provincial approved rate of $221 per hour. Specifically, physicians are provided a supervision / program planning stipend of $4030* per FTE PCN employee working in their clinic. The stipend of $4030* is calculated based on the estimated number of physician hours (~18 hours per year) compensated at the expected provincial approved hourly rate (currently $219/hr).
- Inflation & Wage Rate Increases: The PCN has historically followed wage rate increases that have been provided to provincial UNA staff. The provincial UNA agreement is not finalized for the duration of the business plan. The PCN has therefore not provided for any wage increases for the business plan renewal. When the UNA negotiations are completed, the PCN will assess the UNA settlement and determine whether adjustments to PCN wage rates are required.
- Employee benefits: Employee benefits and allowances represent approximately 11% of base salaries.
- PCN Resources Provided Based on Physician Panel Size: Based on the grant funding available each year, the PCN Board may establish restrictions on PCN resources that are required to operate a financially sustainable PCN. The restrictions recognize the budgetary impact of the PCN's grant funding methodology, which is a patient panel capitation model.
- Part-time PCN Employees: Compensation provided to physicians for supervision/program planning and rental/clinic supports will be proportional to the FTE of the RN/Other Health Professional located in the physician's office.

5. Legal Structure

1. Legal Form of Business:

The PCN went live on August 1, 2006, and the legal framework was set up at that time using the "Provincial Legal Model #2" (without modification). Under this model the participating physicians incorporated a non-profit corporation ("Palliser PCN Physician Group") on June 5, 2006. This Physician NPC and AHS entered into a Joint Venture Agreement (dated June 5, 2006) which created the "Palliser Primary Care Network" (incorporated July 20, 2006). The Palliser PCN has a PCN Board, comprised of Physicians, AHS employees (and physicians) and a Community Director that oversees the implementation and operations of the Palliser PCN.

2. Term of Agreement:

The initial 3 year business plan was approved for the period from August 1, 2006 to July 31, 2009. The current business plan renewal is for the period from April 1, 2021 to March 31, 2024, with further business plans renewals anticipated thereafter.

3. Business Plan Implementation, Review and Consideration of Amendments:

The Physicians and AHS have made their best efforts to develop a comprehensive business plan that will govern the operations of the PCN. However, there is recognition by both parties that the PCN is a dynamic entity and that the business plan may need to be adapted as time progresses to the needs of primary care in this geographical area.

Responsibility for implementing, monitoring, and consideration of amendments to the business plan rests with the PCN Board. Regular review of the business plan will occur on a 12 monthly basis or as required. Any deviation from the business plan must be reviewed/approved by the PCN Board and material changes must be submitted to AH for their review/approval.

Signatories to the business plan acknowledge that all material changes to the business plan require prior written approval of AH, as specified in Policy Manual, and that they agree to abide by AH's policies regarding business plan amendments as may be developed and amended from time to time. Signatories to the Business Plan acknowledge that all material changes to the Business Plan are aligned and approved as per the PCN Legal Model (JVA) per the AH Policy Manual.

The Business Plan is used by PCN Administration, participating physicians, and employees on a day-to-day basis to guide PCN administrative and clinical activities. The Business Plan is used to anchor PCN Board policy

development on an ongoing basis. The Business Plan is formally reviewed as part of the PCN Board governance development.

4. Entry/Exit of Physicians

The PCN allows flexibility for physicians who wish to enter or exit the Physician NPC and therefore the PCN agreement. The process by which a physician can exit the PCN is detailed in Section 3 of the Physician NPC bylaws as follows:

> *A Member of the Physician NPC shall cease to be a Member upon giving notice in writing to the Physician NPC of their intention to withdraw from Membership. The notice will take effect upon the date received by the Company or at the time specified in the notice, whichever is later.*

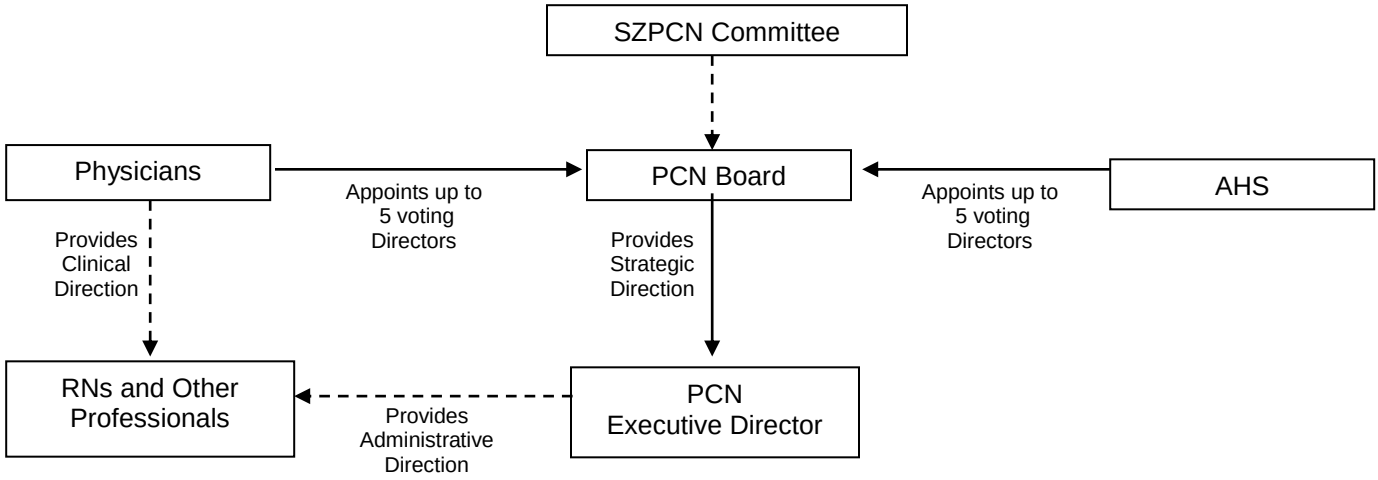
5. Termination Provisions

The legal agreements forming the Palliser PCN have no specific term end dates and will continue so long as the Physician Group and AHS agree to maintain the PCN. The process by which either party may terminate the PCN is detailed in Section 3 of the Joint Venture Agreement.

6. PCN Governance and Organization

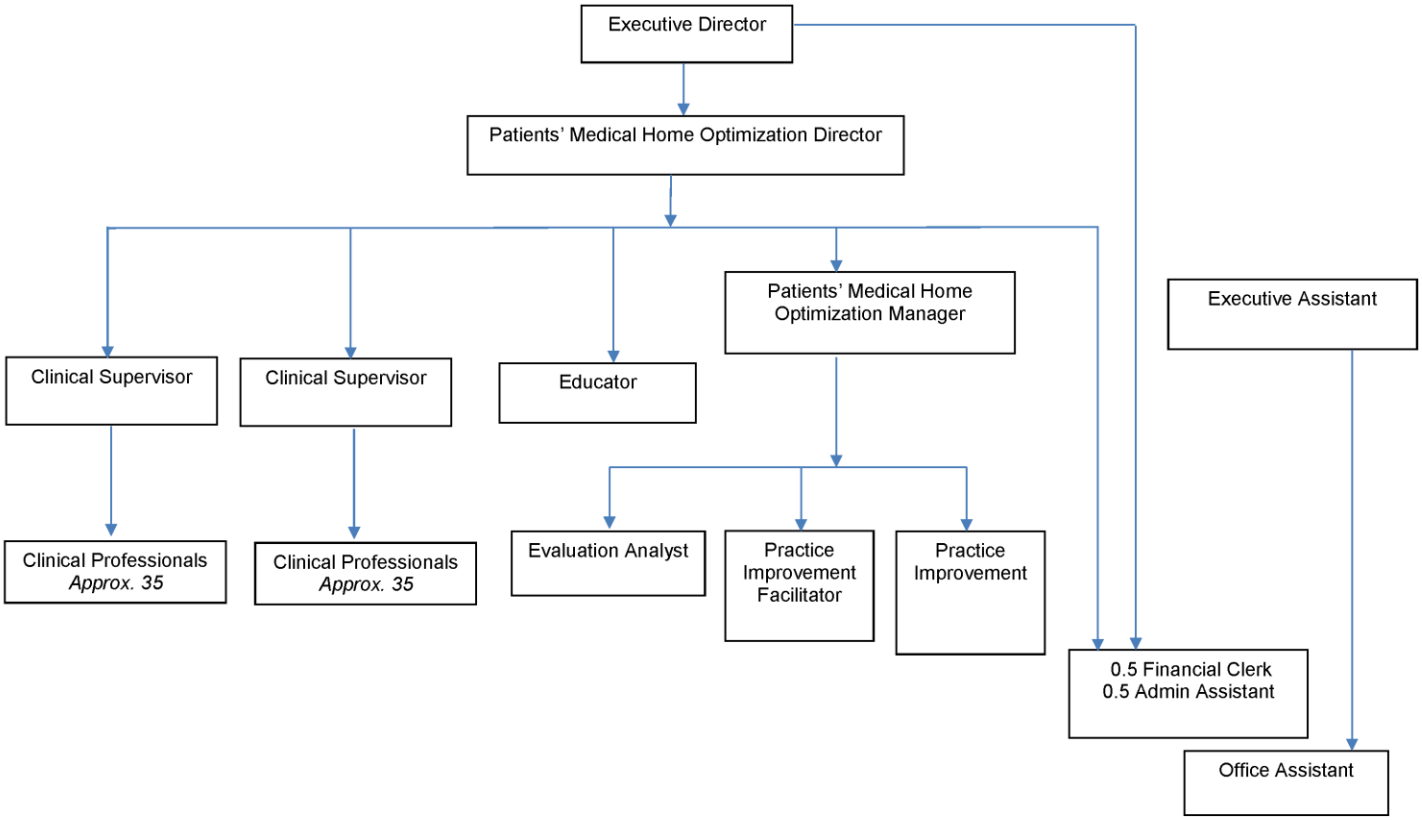
1. <u>Governance Organizational Structure:</u>

The Palliser PCN has a PCN Board, comprised of Physician and AHS representatives, that oversees the implementation and operations of the Palliser PCN.



Note: the PCN has appointed an additional interim non-voting physician board member to serve as representative on the Zone PCN Committee.
Note: one of the AHS positions is held by the Community Board member.

Operational Organizational Structure



PCN Executive Director – Roles and Responsibilities

- Provision of support to physicians in the development and implementation of their primary care network service plan and practice improvement plans.
- Facilitate easy access to tools and resources for primary care teams.
- Assist physicians in recruitment of RNs / Other Professionals, including supporting the training and integration of team members.
- Providing ongoing human resources and payroll support to PCN staff.
- Overall administration of the PCN.
- Ensuring the provincial PCI principles are adhered to and that required provincial reporting and evaluation is completed.
- Ensuring that the principles and instructions of the PCN Board are adhered to.

2. Dispute Resolution:

- The PCN Board members will use rational, objective decision-making processes that are supported by administrative recommendations and an assessment of risk.

- Decisions will be aligned with the mandate, principles and strategic goals of the PCN, taking into account the respective interests of the partners and the parameters established by AH.
- On any matters requiring the decisions of the PCN Board:
  - Decisions can only be made at duly constituted meetings of the Board.
  - Where possible, the decision will be made by consensus of all members attending the Board meeting.
  - A Board resolution will be passed where,
    i. a majority of the Directors present at the meeting vote in favour of the resolution; and
    ii. at least 50% of the Directors appointed by AHS and 50% of the Directors appointed by the Physician Group, present at the meeting, vote in favour of the resolution.

Should the Board be unable to come to a resolution they will follow the dispute resolution process as detailed in Section 6 of the Joint Venture Agreement.

3. Physician – PCN Charter

The PCN was jointly established by the participating family physicians and Alberta Health Services with a commitment to work collaboratively to develop and implement primary care delivery models aimed at improving appropriate access, quality of care and satisfaction for both patient and health care providers.

The purpose of this Charter is to clarify and articulate the interdependence and commitment of the PCN and participating family physicians as they move forward with primary health care evolution specifically focusing on Health Home Optimization. A stronger alignment between the PCN and the participating Physicians will enable Palliser PCN to be successful in meeting the goals and objectives as set forth within PCN Grant Agreements and the associated stipulated requirements and obligations. In this spirit, the parties agree to work jointly together to do the following:

1. Formation and ongoing improvement of high functioning Health Home teams respecting the unique context of each clinic	
Physicians will: • take a leadership role in leading a high functioning Health Home team including actively participating in PCN employee hiring, evaluations and ongoing improvement • be actively involved in clinic team meetings and clinic team evaluation.	**PCN will:** • recruit, educate and HR manage professional staff who are dedicated to working to their full scope of practice in support of the full physician panel • affirm physicians who wish to engage in the Physician Champions program and/or PMI training • provide Facilitator support and tools such as team assessment, team education sessions and meeting support and follow-up
2. Evidence based organizational and clinical practices implemented, evaluated and improved in an ongoing manner	
Physicians will: • Provide the PCN with direct access to gather data for the purpose of measurement and improvement. This data may come from paper or EMR charts. • Current physicians without EMRs will be grandfathered to remain PCN members, however all new physicians joining the PCN will be expected to have an EMR and provide the PCN remote access code. • Provide remote EMR access to the PCN where it is technically available	**PCN will:** • Provide evaluation and facilitation support to optimize and standardize use of the EMR within a single clinic • Provide reports and supports to clinics as appropriate for the purpose of ongoing improvement
3. Staying abreast and adopting changes required to optimize Health Homes and adapt to provincially required changes	

Physicians will:
• Be informed members of the PCN and aligned with the PCN strategic direction. Actions include but are not limited to:
  ○ Keeping abreast of communications from the PCN
  ○ Completing PCN surveys
  ○ Engaging in discussions with PCN Board and Admin team as appropriate
  ○ Adhering to PCN policies, as applicable.
	PCN will:
	• Regularly and proactively share information and gain feedback regarding strategic intent, priorities and business decisions.

4. Consequences for Failure to meet Obligations

The PCN operates under legal model #2. Therefore both parties (Physician Group and AHS) jointly deliver and are accountable for the PCN service responsibilities, as detailed in Section 2 of the Joint Venture Agreement. Towards this end, based on current Alberta Health guidelines, participating physicians who are actively engaging in Health Home Optimization will be expected to:

- submit third next available data via the PCN online measurement tool, and
- provide the PCN with remote EMR access, and
- engage in consistent and accurate panel verification which can be verified by the PCN, and
- engage in within-clinic standardized EMR optimization, and
- engage in appropriate opportunistic and outreach screening, and
- engage in within-clinic team optimization including completing a team effectiveness survey, and
- complete PCN wide and within clinic surveys.

Participating physicians are therefore eligible to receive the following from the PCN:

- in-clinic professional clinical support (e.g. registered nurse, behavioural health consultant, dietitian, pharmacist), and/or
- facilitator, panel optimization coordination and/or evaluation support to work towards continuous practice improvement including panel verifying, access improvement, and clinic efficiency and effectiveness, and
- supervision/program planning payments as outlined in the budget, and
- rental/clinic support payments as outlined in the budget.

The above list may change from time-to-time. Physicians will be provided with a minimum 3 months' notice of any changes impacting requirements of physicians or resources available from the PCN.

Where a physician is not meeting the above requirements, the PCN will work with the physician towards improvement. As a last resort, the PCN may introduce sanctions such as: removal of supervision/program planning payments; removal of rental/clinic support payments; removal of in-clinic professional clinical support; up to and including removal from the PCN.

7. Information Management

Current State of Information Management

AHS:

- AHS provides a region-wide hospital based information system (Meditech). This includes hospital provided laboratory and diagnostic imaging, summary of medical consults and admission and ambulatory care history.
- Availability of Meditech information is region-wide; however, access may be a barrier to its consistent use at the clinic level. PCN staff assist in improving utilization of clinical information.

Provincial Information System:

- Most physicians/PCN employees access Netcare.
- Some clinics may choose to participate in CPAR/CII over the coming years. There are two clinics enrolled in CPAR/CII.

Physician Office Information Systems:

- Approximately 95% of participating PCN physician offices in the PCN geographic area region are automated or are moving towards automation.
- The following chart outlines the use of EMR software within the PCN:

EMR Vendor Name	# of Physicians in the PCN Using this Vendor's Software
QHR Accuro	27
QHR Accuro (scheduling/billing only)	2
TELUS Wolf	42
TELUS Med Access	14
Other EMR	2
Total	87

Information sharing opportunities exist between PCN providers and AHS programs and services. Email automation varies from clinic to clinic. Access to clinical updates online again varies from clinic to clinic. Most providers continue to receive clinical practice information by hard copy and time limits their opportunity to access online information. Netcare rural feeds are slow with limited functionality.

The PCN is committed to privacy of information and only the appropriate health information required to provide patient care will be accessed or shared within the PCN. The PCN has appropriate Information Management Agreements and Data Retrieval forms with participating physicians.

7.1. Privacy Impact Assessment Status

In preparing the renewal business plan, a number of clinics were identified where the PCN is in the process of verifying PIA completion and/or status. 63% of clinics have an up-to-date PIA and 30% of clinics currently have a PIA update in progress.

# of Physicians Covered	Clinic/Physician Office	File Number for Accepted PIA
1	Badlands Medical	(submitted)
2	Bassano Medical Clinic (Bassano)	H3421
5	Bow Island Medical Clinic (Bow Island)	#013159
2	Brooks Medical Clinic (Brooks)	H3113
5	Centennial Medical Clinic (Brooks)	#012203
5	Newell Associate Medical Clinic (Brooks)	#00903
3	Oyen Medical Clinic	H5077
1	Redcliff Family Practice	#012792
5	South Shore Medical Clinic (Brooks)	#000982
1	Cameron Medical Clinic (Medicine Hat)	#005421
1	Carry Drive Clinic (Medicine Hat)	#002463
1	Carry Drive Clinic (Medicine Hat)	H3642
1	Carry Drive Clinic (Medicine Hat)	#002361
1	Carry Dr. Clinic Medicine Hat)	H3395
6	Crescent Heights Family Medical (Medicine Hat)	H2989
3	Daramola Medical Clinic	#006788
1	Dr. Ian Gebhardt	H4814
1	Greenbrook Medical Clinic	(submitted)
1	Hat High Medical Clinic	(submitted)
1	Health Matters Medical Clinic (Medicine Hat)	H3786
8	HealthWORX Medical Clinic (Medicine Hat)	#004280
1	Hrdlicka Family Practice (Medicine Hat)	H3298
2	Jacaranda Medical Clinic (Medicine Hat)	H5341
1	Living Hope Centre (Medicine Hat)	H4152
1	Dr. Doug Mastel	#013765
2	Meiring and Kriel Family Practice (Medicine Hat)	H4429
3	Mohawk Medical (Medicine Hat)	#006978
1	Primacy Clinic (Medicine Hat)	#005593

# of Physicians Covered	Clinic/Physician Office	File Number for Accepted PIA
1	Primacy Clinic (Medicine Hat)	#005975
1	Dr. Gerry Prince	#007357
1	Dr. Fredrykka Rinaldi	#001213
2	Riverside Medical Clinic (Medicine Hat)	#0044855
1	Dr. Viren Saujani	#013536
3	Southlands Medical Clinic West (Medicine Hat)	#014516
3	Southview Clinic (Medicine Hat)	#010612
1	The Avenues Clinic (Medicine Hat)	#005509
3	The Hill Centre (Medicine Hat)	(submitted)
1	The Ridge (Medicine Hat)	H3298
1	Dr. Martin Wong	H1346
1	VistaPark Medical Clinic (Medicine Hat)	#000899
2	13th Avenue Clinic (Medicine Hat)	#005328
91	PIA for the PCN	H1346

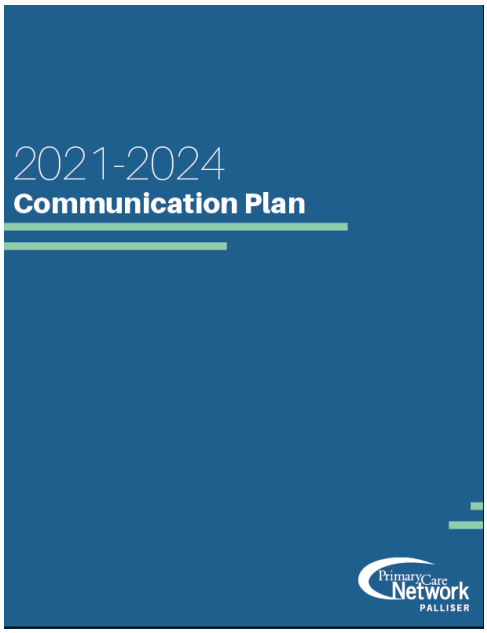
8. Risk Assessment

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Financial Risks		
• Occurrence of a deficit	• PCN financial policies are reviewed annually and adhered to. • The PCN Board monitors financial results at the monthly board meeting. This monitoring includes variance analysis. • The PCN Board reviews budget projections twice per annum.	• Adjust spending based on variance analysis at least on a quarterly basis. • The PCN has placed hard caps on its significant expense areas (i.e. employee FTE).
• Uncertain funding amounts as enrollee numbers change	• Monitor policy development regarding funding. • Monitor enrollee data reports, verify where enrollees are receiving services outside of the PCN and bring this information back to the PCN Board with recommendations.	• The PCN may have to adjust its spending should enrollee numbers change unexpectedly.
Patient Safety, Legal, and Liability Risks		
• Liability associated with sharing of care among multidisciplinary team members	• Ensure all healthcare professionals, including physicians, are appropriately credentialed and insured.	• Address matters of concern promptly.
• Adverse patient outcomes resulting from presence at or treatment through PCN programming	• Provide a comprehensive ongoing education and supervision program for PCN employees. • Establish protocols for patient treatment and ensure that PCN staff are aware of their professional scope. • The PCN carries comprehensive liability insurance.	• Notify representatives of the Board and Alberta Health. • Ensure appropriate communications channels are utilized promptly.
Human Resource Risks		
• Inability to recruit and retain qualified staff	• Establish a positive work environment for staff. • Provide education and growth opportunities for staff. • Endeavor to promote within. • Provide competitive salary and benefits within means.	• Develop alternate service delivery methodology.

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Health Information and Privacy Risks		
• Breach of patient privacy.	• PCN Employee handbook and professional codes of conduct address privacy risks. • Annual review of privacy policy/procedure. • Annual privacy training.	• Address matters of concern promptly.
Other Risks		
• Patient volumes overwhelm program resources	• Manage intake. • Implement program delivery on a phased basis.	• Adjust plans and resources as necessary.

9. Communications

The Palliser PCN has established communication processes during its first fourteen years of operations that permit all stakeholders to be regularly updated on the services and progress of the PCN. These processes have included media, pamphlets, email reports and meetings of employees and physicians. The PCN expects that these processes will continue to be improved in the future.



PCN Communication Plan – Cover

PCN Patient Pamphlet – Example

PCN Health Home Logo – used in communication materials

Audience	What will be communicated
• Alberta Health • PCN Board • PCN physicians • AHS	• Performance measures and Financial reports • Changes to service delivery • Physician entry/exit • Other major issues
• PCN Patients	• Health Home information • Changes in service options and delivery • Expanded access details • Invitations to provide feedback
• PCN Employees	• Performance measures and Financial reports • Changes to service delivery • Clinical Guidelines and Best Practices • Other major issues

10. Evaluation of the PCN

Overall PCN success will be measured by the successful implementation of inter-professional Health Home teams, the delivery of quality care to a defined population, a demonstrated improvement in appropriate access to quality primary healthcare resources and the maintenance of a high level of satisfaction for physicians with the delivery of primary care services.

Evaluation of the primary care network is intrinsic to the measurement & improvement program that is operated by the Palliser PCN. The PCN does not consider evaluation to be a separate exercise in and of itself but rather a component of a continuous improvement program. For this reason, the PCN does not budget separately for evaluation, but instead combines these resources into its "Measurement & Practice Improvement" program.

The guiding principles for the PCN's evaluation plan have remained focused on striving for evaluation efforts to produce data which not only meets the needs of the PCN and AH, but, most importantly is informative to the clinic regarding the service the clinic is providing and/or the health and wellbeing of the patients to whom the clinic provides service. The PCN has continued to ensure it is meeting the expectations of the patients, physicians and employees of the PCN through the use of surveys. As well, the clinics who have participated in formal practice improvement learning sessions (AIM and PCN Health Home Development Series) are supported to measure and evaluate their access and efficiency within the clinic. This work continues to grow incrementally throughout the PCN. Each clinic is supported by the PCN to measure at the complexity level that the PCN and clinic are able to support. The evaluation model and priorities of the PCN are made through ongoing discussions with Alberta Health, Alberta Health Services, the participating physicians, the PCN Employees and clinic staff. The PCN will endeavor to meet mandatory Schedule B reporting requirements and consider health system outcome indicators. It is important to balance academia and praxis within the resources of the PCN.

During the course of the 2021-2024 Business Plan, the PCN will continue to assist clinics to optimize EMRs and measure for improvement purposes – this will have the side effect of facilitating more accurate measurement aggregated at a PCN level. Although some clinics are being assisted to review population data from external sources like the HQCA, the majority of actionable data is pulled directly from each clinic's electronic medical record. This approach will ensure that measurement is part of clinical practice and is used to inform clinical practice rather than becoming an activity unto itself.

2019-20 Annual Report Evaluation Highlights:

Annual Report Highlights

Primary Care Network PALLISER

Average time to third next appointment (TNA) for PCN RNs/OHPs is **5 days**

Currently Measuring TNA:

100% of RNs/OHPs

98% of Physicians

Average no-show rates:

PCN Physicians: 5%

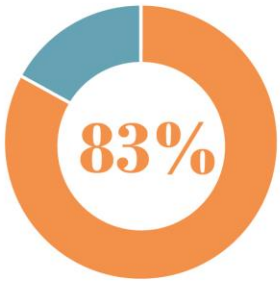
PCN BHCs: 9%

PCN non-BHCs: 4%

23

Health homes assisted to create/update PIAs in the last 18 months

Screenings of 30,000 patients seen by a PCN RN/OHP in the last year:



of patients with blood pressure charted in the last year

of Hypertensive patients with last BP < 140/90 (controlled)

94% of patients screened for diabetes (A1c or FBS in 5 years)

95% of diabetic patients with A1c in last year

88% of patients with a weight charted in the last 3 years

Utilization :

56

minutes on average per patient (PCN Staff)

Average number of unique patients seen per year, per 1.0 FTE:

750

Plan for evaluation, by Provincial Objective

Objective 1: Accountable and Effective Governance

Evaluation activities:

- Measure initiatives, achievements and barriers regarding board retreat, orientation, manual, governance training, development items
- Describe Executive Director and board assessment, board retreat and action planning
- Report and analyze both Schedule B indicators under this objective
- Sample Governance Accountability infographic:

Objective 2: Strong Partnerships and Transitions of Care

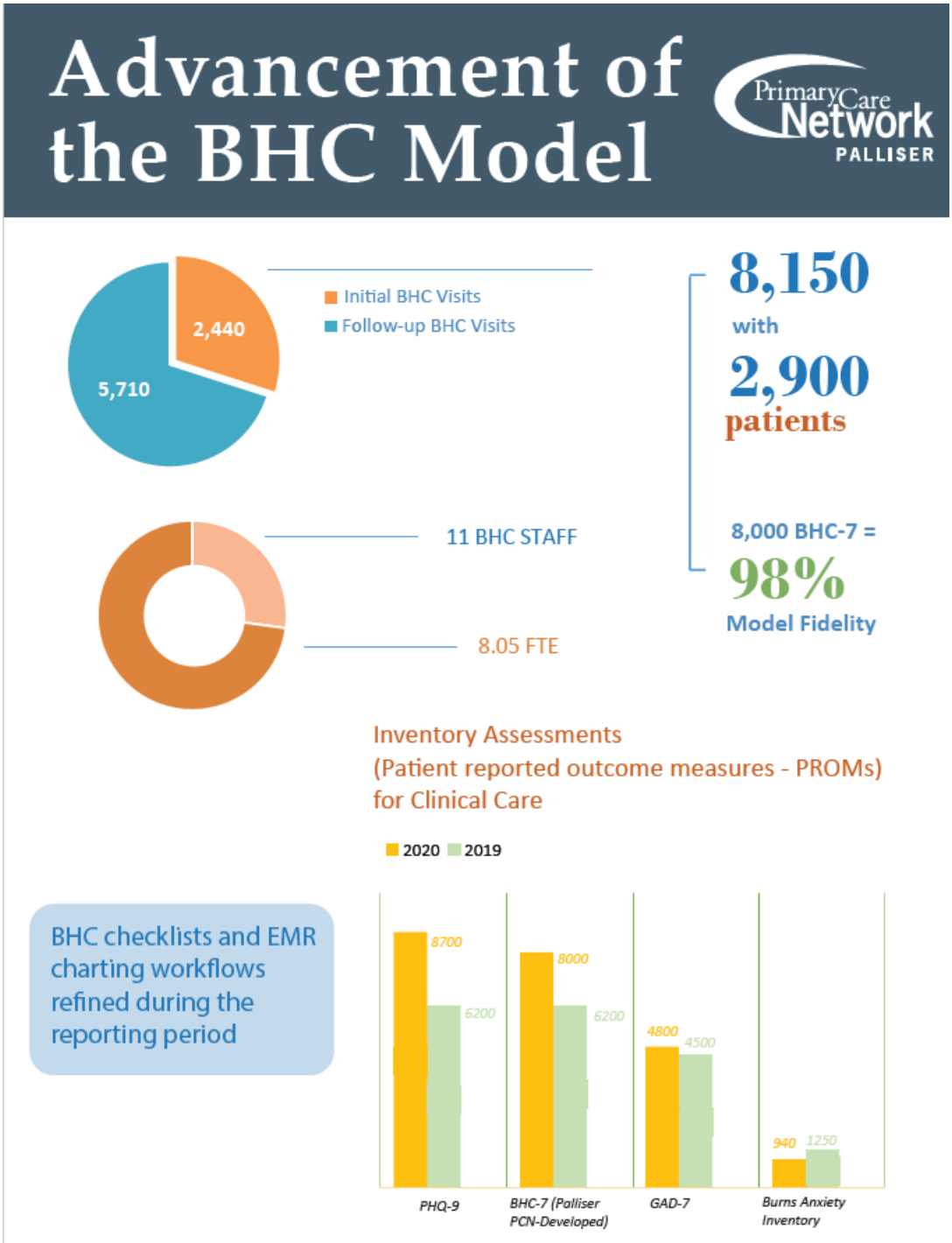
Evaluation activities:

- Measure activities undertaken to improve coordination and integration with other health services, including after-hours physician service, ER, Health Link
- Summarize patient access to public walk-in clinic listing, physicians accepting new patients, local community resources (website page views)
- Report on ongoing PCN support with EMR optimization within the health home, including percentage of health homes where the PCN has remote access, addition of electronic referral documents to EMRs, support with CPAR/CII enrollment, eDelivery, eReferral, Netcare
- Describe AHS and community non-profit partnerships including methods of partnership (e.g. workshops, staff meetings, PCN website postings)
- Summary of EMRs used in Palliser PCN and electronic form support (95% of clinics with PCN remote access)

Objective 3: Health Needs of the Community and Population

Evaluation activities:

- Describe use of external, population level reports, e.g. HQCA, AH, AHS and other local community reports
- Summarize health home data and clinical practice improvement activities to meet community and population needs
- Measure advancement of Behavioural Health Consultant (BHC) model
- Report and analysis of Schedule B indicator under this objective
- Assess other PROMs in use in Palliser PCN
- Summary of Advancement of BHC Model, as at March 2020:



Objective 4: Patient's Medical Home (PMH)

Evaluation activities:

- As summarized under each subsection below; includes reporting and analysis of Schedule B indicators

4a: Care Coordination

- Summarize and describe triangulation of annual PCN patient, physician, employee survey results

4b: Enhanced Access

- Describe PCN RN/OHP and physician collection of Third Next Available Appointment measure
    - 100% of PCN RNs/OHPs and 98% of physicians are measuring time to third next available appointment

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

- Report on support to update patients, community resources, emergency departments, walk-in clinics on physicians currently accepting new patients
- Measure PCN website public walk-in clinic listing website usage

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

- Encapsulated within Objective 2 evaluation activities

4c: Patient Centred Interactions

- Lift and interpret relevant patient survey and patient experience (Schedule B) survey results

4d: Organized Evidence Based Care

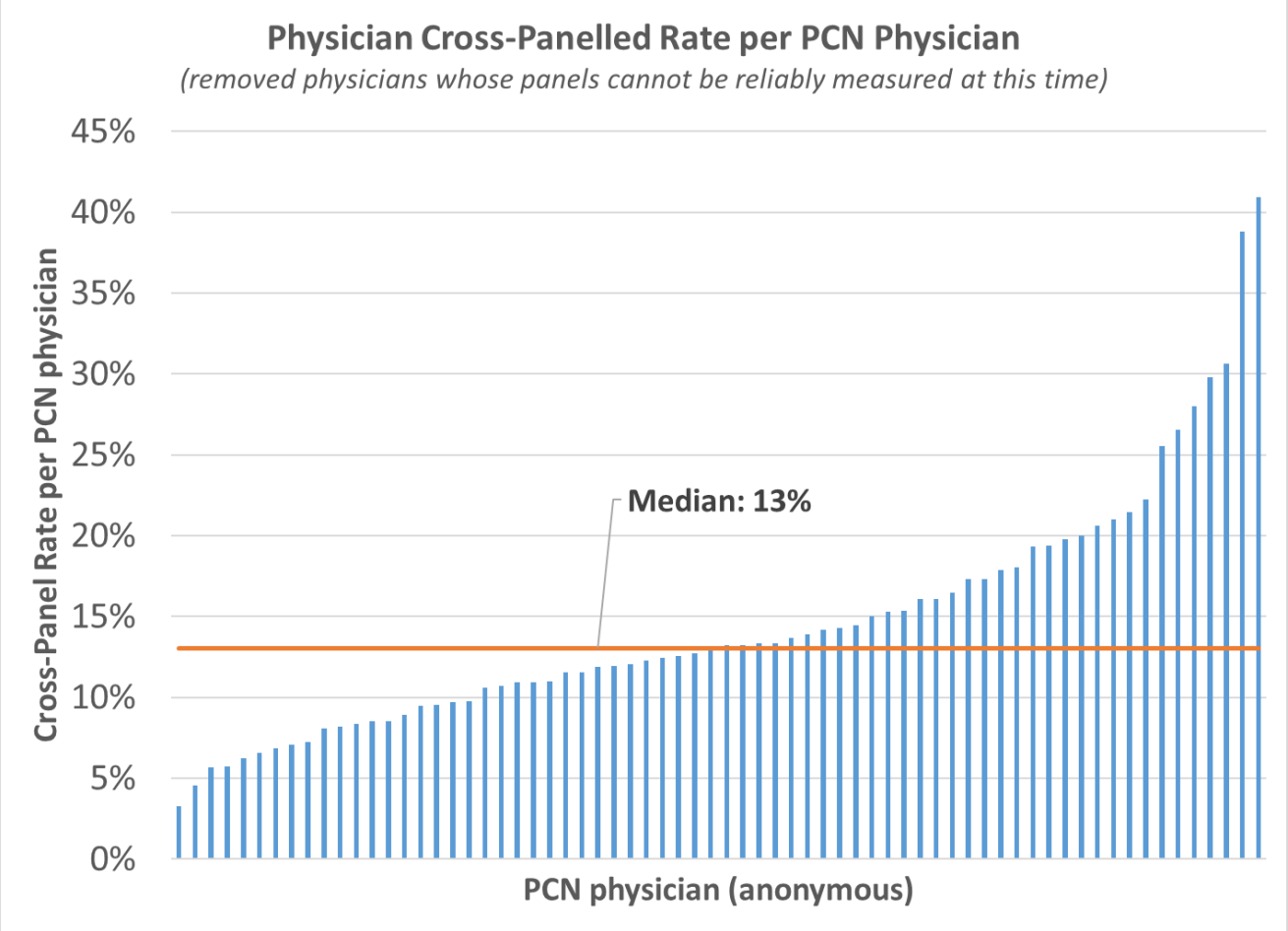
- Report on screening indicator (Schedule B) results and describe relationship between screening measurement and process improvement

4e: Team Based Care

- Provide Team Effectiveness Schedule B Progress Indicator measure and describe team effectiveness surveying in Palliser PCN

4f: Panel & Continuity

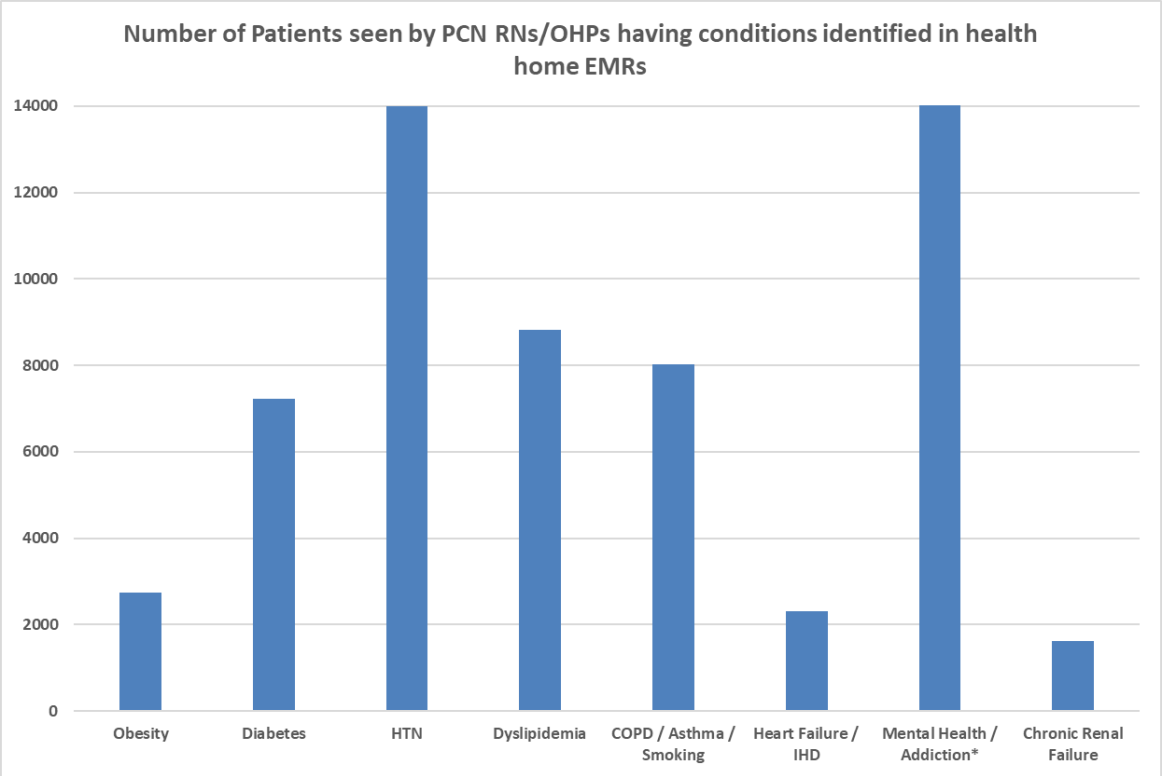
- Document PCN's ongoing work to support increase in PCN physicians engaging in panel verifying activities, including progress toward increased CPAR/CII enrollment
- Describe measurement of continuity and PCN-wide cross-panelled rate, its use in individual clinic practice improvement work and preparations for its use in PCN staffing calculation
- Summary of PCN cross-panelled rate, per PCN physician (April 2020):

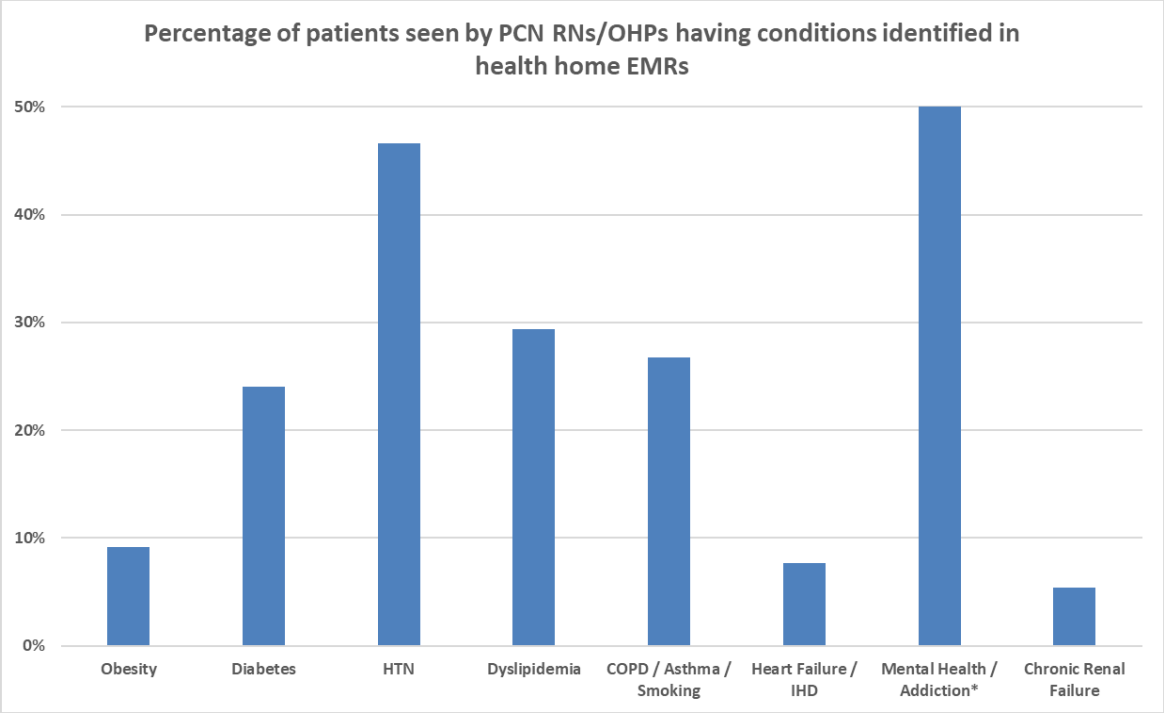


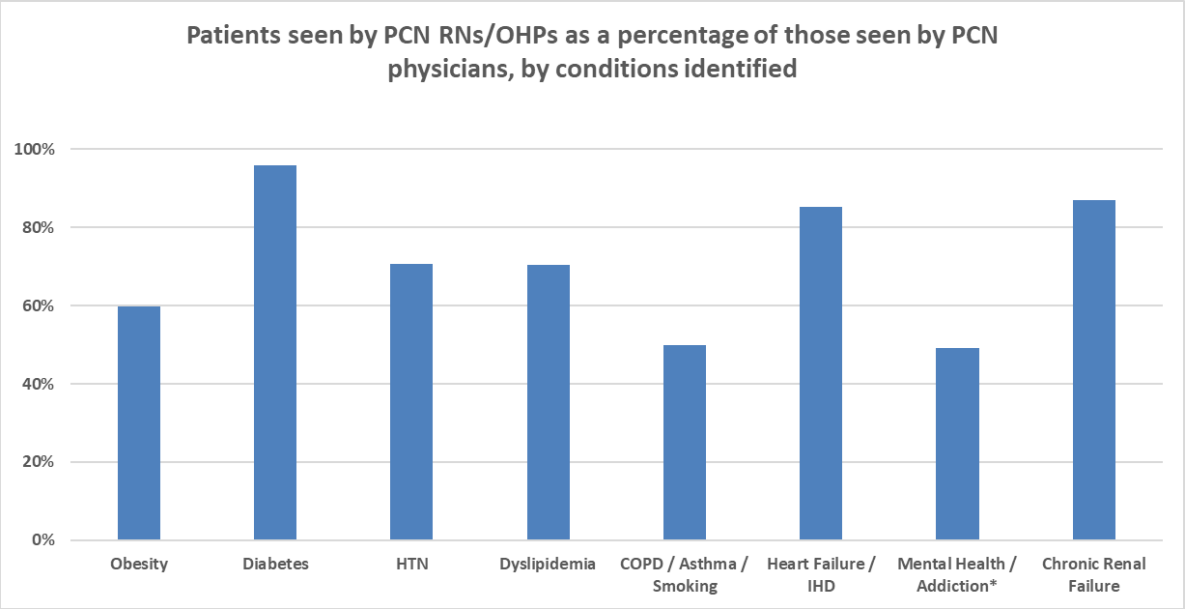
- Explain use of other continuity data at the clinic and PCN level, e.g. HQCA panel reports

4g: Capacity for Improvement

- Review tools used to support clinical practice improvement and aggregate summary of PCN data extracted from clinic EMRs
- Selected highlights from most recent evaluation activities:







Domain	Measure	Seen by RN/OHP	Seen by Physician
Hypertension screening	% of patients seen with BP charted in last year	83%	74%
Hypertension management	% of patients with hypertension seen with most recent BP <140/90 (controlled)	89%	83%
	% of patients with hypertension seen but missing BP in last year	6%	14%
Diabetes screening	% of patients seen with A1C or FBS in last 5 years	94%	86%
Diabetes management	% of diabetic patients with A1C in last year	95%	91%
	% of diabetic patients with a most recent A1C value < 7.0	48%	48%
	% of diabetic patients with a most recent A1C value < 8.0	72%	70%
	% of diabetic patients with a most recent A1C value < 9.0	85%	82%
Tobacco use screening	% of patients seen with an identified smoking status	81%	69%
Weight management	% of patients seen with a weight measurement in last 3 years	88%	80%

4h: Engaged Leadership

- Encapsulated within Objective 1 evaluation activities

Annual Report Evaluation Template:

The evaluation questions in the annual template will be addressed through present data gathering processes (activity tracking tool, physician survey, employee survey) and the development of additional data gathering processes (patient survey, practice improvement measures).

The PCN anticipates being able to meet the evaluation standards outlined in the annual PCN grant funding agreement.

Resources:

In addition to leveraging existing EMR data for clinic measurement, the PCN currently utilizes PCN employees limited additional data gathering, e.g. Third Next Available collection. For those limited paper-based clinics, activity and clinical tracking is completed outside of an EMR. A 1.0 FTE PMHO Manager, 1.0 FTE Analyst and 1.0 FTE Assistant are provided centrally to assist with evaluation. As well, the 2.0 FTE Practice Improvement Facilitators are utilized to support the clinics in standardizing EMR data entry and collecting and analyzing the data.

Collaboration / Partnerships

The PCN will depend on AHS to provide access and analyze data related to inpatient admissions. The PCN will depend on the Measurement and Evaluation Working Group to assist in identification of evaluation priorities and identification of leaders in PCN Evaluation across the province so that best practices in PCN Evaluation can be applied in the local environment.

Appendix A: Service Delivery Plan by Service Responsibility

Service Responsibility	Description of the programming and resources currently available to address the service responsibility	Direct ways in which the PCN intends enhance delivery of care during the term of this business plan
1. Basic ambulatory care and follow-up	• Currently provided in Physicians' offices.	• The addition of RNs / Other Professionals to physician offices will assist with follow-up of patients (with a focus on chronic disease). As well, RNs / Other Professionals should free up additional physician time to improve appropriate access for attached and unattached patients with basic ambulatory care needs.
2. Care of complex problems and follow-up	• Currently provided in physician offices. • Referral to outpatient / inpatient treatment (in AHS facility) and specialist care where appropriate. • Complex problems and follow-up are not a distinct group but rather part of geriatric, mental health and chronic patients.	• RNs / Other Professionals in physician offices will assist in complex care.
3. Psychological counselling	• Currently provided by physician offices and AHS mental health personnel. • Physicians currently diagnose and treat a variety of mental health problems in Physician offices. • Referral to outpatient / inpatient treatment (in AHS facility) and specialist care where appropriate.	• Addition of BHC to physician offices will assist in counselling.
4. Screening/ chronic disease prevention	• Currently provided in physician offices and by AHS public health personnel.	• The addition of RNs / Other Professionals to physician offices will assist in screening and chronic disease prevention.
5. Family planning and pregnancy counselling	• Currently provided in physician offices and by AHS public health personnel.	• Not a focus during this planning cycle. Only indirect improvements anticipated.
6. Well-child care	• Early screening and intervention provided by physician offices and by AHS public health personnel.	• Not a focus during this planning cycle. Only indirect improvements anticipated.
7. Obstetrical care	• The model for obstetrical care is being created through tri-partite planning with AHS, PCN and Family Physicians.	• Not a focus during this planning cycle. Only indirect improvements anticipated.
8. Palliative care	• Currently provided in physician offices. • Referral to AHS Palliative Care program (inpatient and community based care) where appropriate.	• Not a focus during this planning cycle. Only indirect improvements anticipated.

Service Responsibility	Description of the programming and resources currently available to address the service responsibility	Direct ways in which the PCN intends enhance delivery of care during the term of this business plan
9. Geriatric care	• Currently provided in physician offices. • Referral to AHS Geriatric Services and specialist care where appropriate.	• The addition of RNs / Other Professionals to physician offices will assist in disease management in the geriatric population with services such as medication reviews, dementia screening and linkages development with appropriate AHS services.
10. Care of chronically ill patients	• Currently provided in physician offices and through AHS Chronic Disease Management Program.	• The addition of RNs / Other Professionals to physician offices will assist in care of chronically ill patients.
11. Minor surgery	• Currently primary provided in physician offices (and appears to be addressed well).	• Not a focus during this planning cycle. Only indirect improvements anticipated.
12. Minor emergency care	• Currently provided in physician offices during office hours and during after-hours / week-end service hours. • Provided in AHS emergency room facilities 24 hours per day.	• Not a focus during this planning cycle. Only indirect improvements anticipated.
13. Primary in-patient care including hospitals and long-term care institutions	• Currently provided by physicians and staff at AHS operated in-patient and AHS funded continuing care facilities.	• Not a focus during this planning cycle. Only indirect improvements anticipated.
14. Rehabilitative care	• Identification and referral, where appropriate, currently provided in physician offices. • Rehabilitative care (physiotherapy, occupational therapy, etc.) currently provided in AHS facilities. • PCN RNs in physician offices assist with assessment of chronic pain/mobility/obesity issues, patient care plan development, monitoring and referral to AHS Programs and specialists where appropriate.	• The addition of RNs / Other Professionals to physician offices will assist in rehabilitative care of individuals with chronic pain, mobility and obesity issues and linkages development with appropriate AHS services.
15. Information Management	• See Section 7.	• Not a focus during this planning cycle. Only indirect improvements anticipated.
16. Population health	• Currently provided by AHS public health personnel. • PCN RNs in physician offices assist with influenza vaccinations.	• The addition of RNs / Other Professionals to physician offices will assist in specific population health issues as appropriate to the specific clinic panel needs.

Service Responsibility	Description of the programming and resources currently available to address the service responsibility	Direct ways in which the PCN intends enhance delivery of care during the term of this business plan
17. 24-hour, 7-day-per-week management of access to appropriate primary care services	• Currently provided by physicians during office hours and during after-hours / week-end service hours. • Provided by Health link and AHS Emergency Room at all other times.	• Not a focus during this planning cycle. Only indirect improvements anticipated.
18. Access to laboratory and diagnostic imaging	• Currently provided by AHS facilities, including referral to pathologists/radiologists where appropriate.	• Indirect minor improvements anticipated through improvement in health home processes.
19. Coordination of: home care, emergency room service, long-term care, secondary care, and public health	• Currently provided by Physician referral to AHS Home Care personnel, emergency room services, long term care, specialists and secondary care facilities, and public health personnel.	• Ongoing informal linkage development between AHS employees and PCN RNs / Other Professionals for improved communication and coordination. • Development and maintenance of Community Resource Data base, to facilitate communication and referral process.
20. Acceptance into the Primary Care Network's patient population and provision of the service responsibilities to an equitable and agreed upon allocation of unattached patients.	• Currently there is a shortage of physicians in Alberta. • There are 8 physicians within the PCN accepting new/unattached patients.	• The continued increase in RNs / Other professionals working within the physician offices should reduce the workload on the family physicians. • The physicians may be able to use this freed up capacity to absorb unattached patients.

Business Plan Agreement – Alberta Health Services Representatives

We the representatives of Alberta Health Services undertake to use all reasonable efforts available to us to ensure the goals and objectives and Services Responsibilities of the Business Plan for Palliser PCN are met.

We agree to amend the Business Plan to include any changes to the Service Responsibilities approved by Alberta Health. We also agree to abide by all Primary Care Network-related policies implemented by Alberta Health as currently exist and as may be made and/or amended from time to time, including those regarding reporting, financial reporting and accountability.

South Zone Senior Operating Officer

Grant Walker		
Name	Signature	Date
South Zone Senior Operating Officer	403.388.6525	Grant.walker@albertahealthservices.ca
Title	Telephone	Email

Business Plan Agreement – Participating Physicians

I being one of the participating physicians in the Palliser PCN, until such time as I resign or am removed as a participating physician, undertake to use all reasonable efforts available to me to ensure the goals and objectives and Service Responsibilities of this Business Plan are met. For so long as I am a participating physician, I agree to amend the Business Plan to include any changes to the Service Responsibilities approved by Alberta Health and agree to abide by all Primary Care Network-related policies implemented Alberta Health as currently exist and as may be made and/or amended from time to time, including those regarding reporting, financial reporting and accountability.

Signature Sheets Attached.

Palliser Primary Care Network

Additional Financial Plan Detail for: Professional Support Within Health Homes

in thousands of dollars										
Expenditure Description	**Apr 2021 - Mar 2022**			**Apr 2022 - Mar 2023**			**Apr 2023 - Mar 2024**			**Term**
	Units	Rate	**TOTAL**	Units	Rate	**TOTAL**	Units	Rate	**TOTAL**	**TOTAL**
Physician payments:										
Supervision/ program planning stipend	51.5	$4.03	$208	51.5	$4.03	$208	51.5	$4.03	$208	$624
Office rental/clinic supports	51.5	$3.29	$169	51.5	$3.29	$169	51.5	$3.29	$169	$507
Workshop stipends			$40			$40			$40	$120
			$417			$417			$417	$1,251
Staffing:	FTE			FTE			FTE			
Registered Nurses	39.95	$91.2	$3,643	39.95	$91.2	$3,643	39.95	$91.2	$3,643	$10,929
RN - Educator	1.00	$98.0	$98	1.00	$98.0	$98	1.00	$98.0	$98	$294
Behavioral Health	9.00	$95.0	$855	9.00	$95.0	$855	9.00	$95.0	$855	$2,565
Dietitians	0.90	$95.0	$86	0.90	$95.0	$86	0.90	$95.0	$86	$258
Nurse Practitioners	1.65	$125.0	$206	1.65	$125.0	$206	1.65	$125.0	$206	$618
	52.5		$4,888	52.5		$4,888	52.5		$4,888	$14,664
Other expenses:										
RNs / OHCP: Education, training & orientation			$60			$60			$60	$180
RNs / OHCP: Travel, medical & IT equipment, and other supplies.			$85			$85			$85	$255
			$145			$145			$145	$435
Total Expenditure			$5,450			$5,450			$5,450	$16,350

Palliser Primary Care Network

Additional Financial Plan Detail for: **Measurement & Practice Improvement**

in thousands of dollars										
Expenditure Description	**Apr 2021 - Mar 2022**			**Apr 2022 - Mar 2023**			**Apr 2023 - Mar 2024**			**Term**
	Units	Rate	**TOTAL**	Units	Rate	**TOTAL**	Units	Rate	**TOTAL**	**TOTAL**
Staffing:	FTE			FTE			FTE			
Facilitators, Analysts, & Assistant	6.0	$83.2	$499	6.0	$83.2	$499	6.0	$83.2	$499	$1,497
Travel, supplies & other expenses			$15			$15			$15	$45
Total Expenditure			$514			$514			$514	$1,542

Additional Financial Plan Detail for: **Central Allocations** (PCN Governance & Administration)

in thousands of dollars										
Expenditure Description	**Apr 2021 - Mar 2022**			**Apr 2022 - Mar 2023**			**Apr 2023 - Mar 2024**			**Term**
	Units	Rate	**TOTAL**	Units	Rate	**TOTAL**	Units	Rate	**TOTAL**	**TOTAL**
Physician payments for PCN Board meetings and other meetings:										
Meetings per year			12			12			12	
Hours per meeting			3.8			3.8			3.8	
Physicians per meeting			6			6			6	
Physician Hourly Admin Rate (estimate)			$221			$221			$221	
			$60			$60			$60	$180
Staffing:	FTE			FTE			FTE			
PCN Executive Director	1.0	$175.0	$175	1.0	$175.0	$175	1.0	$175.0	$175	$525
PMHO Director/Clinical Supervisors	3.0	$107.3	$322	3.0	$107.3	$322	3.0	$107.3	$322	$966
PCN Admin. assistants	2.0	$62.5	$125	2.0	$62.5	$125	2.0	$62.5	$125	$375
	6.0		$622	6.0		$622	6.0		$622	$1,866
Other expenses:										
Professional Svcs (Accting, Audit, HR, Legal)			$70.0			$70.0			$70.0	$210
Central Office (Rent, Utilities & Related Costs)			$70.0			$70.0			$70.0	$210
Insurance (Directors, Liability)			$15.0			$15.0			$15.0	$45
Miscellaneous (office supplies, etc)			$28.0			$28.0			$28.0	$84
			$183			$183			$183	$549
Total Expenditure			$865			$865			$865	$2,595

Palliser Primary Care Network

Additional Financial Plan Detail: Expenditure Descriptions

These pages provide additional explanation on the expenditures proposed by the PCN and the resources and allowances that are available to assist physicians and PCN employees in the implementation of the business plan.

Expenditure Item	Funding Available	Detail
PROFESSIONAL SUPPORT IN HEALTH HOMES - Physician payments & allowances		
Supervision / program planning stipend	$4030* (per 1.0 fte)	Though the employer of the RN/Other Professional is the PCN, physicians have some administrative burden related to the supervision of the RN/Other Professional (e.g. review and approval of employee timesheet, participation in employee performance assessment, coaching and/or staff discipline in conjunction with PCN management staff, support of employee lifelong learning plan). Also, physicians have some ongoing Health Home planning, development and evaluation burden (may include individual and/or group meetings). This annual stipend (payable quarterly in arrears) compensates for this administration / planning burden. The stipend is prorated where the PCN employee is < 1.0 FTE. The stipend of $4030* is calculated based on the estimated number of physician hours (~18 hours per year) compensated at the expected AH approved hourly rate (currently $221/hr).
Office rental/clinic supports	$3290* (per 1.0 fte)	The RN/Other Professional will be located within the physician's clinic and will have space dedicated to their needs. The physician will be compensated for rental / clinic supports such as: EMR central office remote access for evaluation/measurement; PCN clinical employee access to the EMR, clinic phones, reception support, medical consumables, office overhead (proportionately) and minor office supplies. This annual stipend (payable quarterly in advance) compensates for this rental/clinic support. This stipend is prorated where the PCN employee is < 1.0 FTE. The stipend is calculated based on the estimated dedicated physical space (80 square feet) multiplied by compensation for rental/clinic support at the estimated market rate of $41.13 per square foot per annum.
Workshop stipends	$40,000 total for all physicians	The PCN provides approximately 4 workshops per year, covering clinical and health home educational topics for staff and physicians. The PCN strongly encourages physicians to attend the health home topics and will provide stipends for physician attendance. An educational workshop may have clinical plus health home components. The total annual PCN budget for this item is $40,000 and this represents the maximum reimbursement that will be approved by PCN in any fiscal year. Generally, each physician will be eligible for stipends for one workshop per year. Physicians will be paid for session attendance, to a maximum of 7.5 hours per session, at the AH approved hourly rate of *$221/hr. The PCN will reimburse physicians for travel and accommodation where the PCN Education events are located outside of their community. Receipted costs for accommodation and travel at 50 cents per km will be reimbursed. Where applicable, meal stipends of $10/breakfast and $20/dinner will be provided.

** These represent maximum funding amounts that would be provided. The PCN Board, as part of its annual budget deliberations and reflective of the funding available and financial priorities of the PCN, may reduce these funding amounts in future years.*

PROFESSIONAL SUPPORT IN HEALTH HOMES – Staffing and Other Expenses	
RNs/Other Professionals	The PCN will provide RNs/Other Health Professionals in physician offices. Pay rates and benefits will be established centrally by the PCN.
PCN staff: Education and training	The PCN will cover education/training costs for PCN employees, including required attendance at all day workshops (approx. 4 per year) & staff meetings (approx. 4 per year). Full education/training details are included in the PCN employee handbook.
Medical & Information Technology Equipment	The PCN will provide the Medical & IT Equipment that is required by the RN/Other Professional to manage chronic disease patients within the physician's office. **Expenditure Criteria:** Reimbursement of receipted costs to purchase medical & IT equipment that meet the following criteria: - must comply with AH guidelines, - must support PCN provided disease prevention and management - should be 'non-operating' in nature (i.e. not supplies, consumables, etc) - must not be considered to be items that are standard in family practice clinics (PCN funds are not permitted to subsidize normal clinic overhead) **Examples of Eligible Expenses:** Medical & IT Equipment to be used by the RN/Other Professional to manage disease, such as desk, chair, computer, dedicated printer (if a shared printer is not available), dedicated phone and teleconferencing equipment. **Examples of Ineligible expenses**: - Fetoscopes, exam tables, otoscopes, opthalmascopes, stethoscopes and any other medical equipment considered to be items that are standard in family practice clinics. - Electronic equipment that is required for normal in-clinic use of the physician or other clinic staff, such as: computers, servers, phones. Employees wishing to access this funding will submit planned expenditures and be individually approved by the PCN in advance of the expenditure proceeding. The PCN will only fund costs incurred within the current fiscal year (i.e. there is no retroactive funding for projects costs incurred in a previous fiscal year).
Promotions & Advertising and Patient Education Materials	The PCN may provide certain Promotions & Advertising and Patient Education Materials to clinics. Promotional materials must clearly advance the communication aims of the Palliser PCN and be in keeping with guidance established by Alberta Health. Clinics wishing to access this funding will submit planned expenditures and be individually approved by the PCN in advance of the expenditure proceeding. **Expenditure Criteria:** Reimbursement of receipted costs must meet the following criteria: - Prior pre-approval from the PCN - must be coordinated through the PCN central office - must contain the PCN logo - may contain the clinic logo **Examples of Eligible Expenses:** - HUTV and one-time installation costs - Patient education/information tear off pads - "patient copy" stamps for PCN employees - *Clinic signage displaying the PCN staff or logo (where signage exceeds $1000 the physician may need to apply for renovation funding) **Examples of Ineligible Expenses:** - Physician service letter/handout (e.g. clinic moving), envelope and stamps for patient mailout or use in clinic - Pedometers, cups, pens, water bottles, measuring tapes etc.