ESPCN 2024/2025 Year in Review

PrimaryCare Network
EDMONTON SOUTHSIDE

As of March 31, 2025

OVERVIEW

In 2024/2025, our stable workforce, along with growth in both our enrollees and membership at ESPCN has enabled us to deliver high-quality services and explore new ways to innovate and make a difference in the lives of our patients.

367 members cared for **409,282** paneled patients.

156,953 MDT encounters with **68,041** unique patients.

CLINICAL SUPPORTS AND SERVICES

ESPCN emphasizes co-located staff to **ensure members and patients have access to team-based care within the medical home**. Access to one-to-one patient appointments with multi-disciplinary team (MDT) is also offered through the **ESPCN central clinic** when the service is not integrated. In addition, group RD visits, group education workshops, exercise specialist programs and services, consulting psychiatry, and our Lower Leg Assessment Clinic (LLAC) can be accessed by referral.

Team-based care optimization has been a central theme this year.

Key projects included:

- New RD referral pathways
- Full-scope PCRN action plan
- Mental health working group
- Cross-training for social workers
- Expanded psychiatry capacity
- Medical Home Optimization toolkit

MDTs integrated into **75%** of clinics

4.2% increase from last year

CLINICAL PROGRAM HIGHLIGHTS

Registered Dietitian Referral Pathways
In addition to the RD triage and group appointment models, outreach referral pathways for malnutrition and anemia were created. These strategies have a high impact on access without needing intensive resources.

Nursing Practice Advisory Committee
The nursing program remained focused on optimizing full scope PCRN practice. A new ESPCN Nursing Practice Advisory Committee that includes nursing leadership and front-line nurses has been established. The committee discusses and advises on issues that impact primary care nursing practice, offering insight, innovative solutions, and recommendations related to scope optimization, team-based care, practice supports, policies and procedures, and evaluation metrics.

Mental Health Working Group
A working group has been established to enhance the BHC role, increase collaboration across other ESPCN clinical team members, and create care pathways for mental health and wellness.

Advance Care Planning
Social work led the launch of a group-based Advance Care Planning program to support patients in making informed decisions about their future health care.

Expanded Psychiatric Support
An additional 0.4 FTE in psychiatry was added, resulting in reduced wait times and improved access to mental health services.

Medical Home Optimization Toolkit
The Medical Home Optimization Toolkit was developed to support quality improvement (QI) across clinic teams. The toolkit includes 15 project options that promote proactive, team-based care. As of March 2025, 30 QI projects have been launched using this toolkit.

PATIENT WORKSHOP SATISFACTION

98%
of patients plan to use class strategies

94%
would recommend classes to others

PATIENT EXPERIENCE SURVEYS

We use patient experience data to guide improvements. **Patient feedback has been consistently positive** with patients reporting that visits with clinicians met their needs and services were delivered in a timely manner.

91%
rated care “excellent” or “very good”

93-95%
satisfaction with core aspects

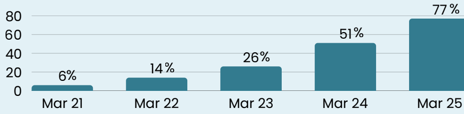
100%
(NP) and

99.3%
(PCRN)
said visits met their needs

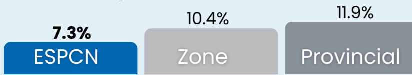
MEDICAL HOME OPTIMIZATION

CII/CPAR Enrollment

ESPCN continued to promote CII/CPAR, raising enrollment from 51% in April '24 to 77% by April '25



CPAR conflict rate remained below the provincial and zone averages at 7.3%.



PLP Partnership and Webinars:
In 2024, ESPCN and PLP hosted a series of Medical Home Optimization webinars which covered topics like FIT kits, lung health, and access to care.

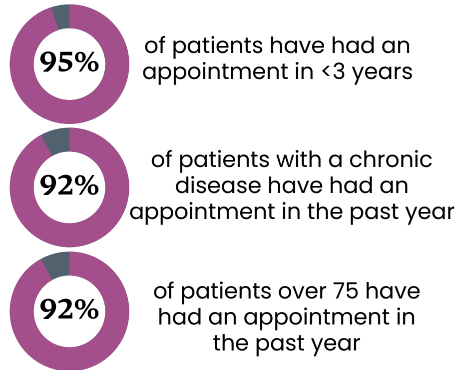
A 7-part PCCA webinar series saw participants from 31 of Alberta's 39 PCNs, and provided valuable resources to enhance patient outreach and care coordination.

PROACTIVE PANEL MANAGEMENT

Outreach is a critical component of panel management. **Proactive Care Coordination Assistants** focus their efforts on re-engaging patients who are overdue for screening or care. This includes those with chronic conditions, seniors, and individuals who haven't seen their primary care provider in several years.

Supporting Continuity of Care

At clinics receiving PCCA support:

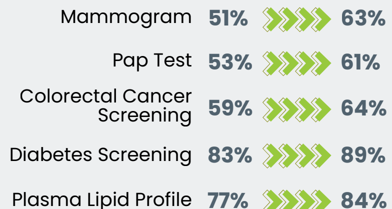


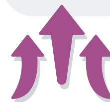
PREVENTATIVE HEALTH SCREENING

ESPCN EMR-Consultants support activation of automated **EMR features**, such as alerts and triggers, to **promote systematic health screening**. Panel-level EMR data is extracted bi-annually for clinics working with a PCCA.

Improved Screening Rates

March 2023 to March 2025





ESPCN EMR screening rates have improved by an average of 7.6% in the past 2 years.

SPREAD OF PCCA SERVICES

79% of eligible members are receiving PCCA services	Online network with **100+** members	Model now in **8** other Alberta PCNs

At ESPCN, we employ **PCCAs who support primary care teams by contacting patients** who are due for care visits or preventative health screening. Each PCCA supports a minimum of 200 patients per week.

SUPPORTED THERAPY

The Supported Therapy Program provides up to **six hours of fully subsidized counseling** from a registered psychologist or registered provisional Psychologist with Cornerstone Counselling. Part of the pilot included a comprehensive evaluation to better understand outcomes from this service. In February 2025, we announced that this evaluation provided meaningful rationale to **transition to a full program** based on the positive, patient-reported outcomes and high demand for this service.

64.6% wouldn't have accessed therapy otherwise

Average **12.7** referrals/week (660 total)

Modest improvement in patient outcomes (PSYCHLOPS) despite long-standing issues

TRANSITIONS OF CARE

ESPCN continues to effectively deliver its Transitions of Care program. This program is seamlessly integrated with co-located PCRNs and has demonstrated success in key areas including **complex care coordination, prioritizing patients at highest risk for adverse outcomes**, and reducing hospital readmission and emergency department visits through timely 7-day follow-up care.

- 6,995 hospital discharges monitored (Jul–Dec)
- 30-day readmission rate: 9% (below zone rate)
- 73% of high-risk patients receive f/up by primary care within 7-day target

COMMUNITY DEVELOPMENT

The Community Development team supports ESPCN's efforts to build **strong community partnerships** that enhance patient care, particularly for vulnerable populations. A key initiative is the **Seniors' Centre Without Walls**, which offers social connection and support for older adults through accessible, community-based programming.

132 topic categories

Average **58** sessions per active participant

896 program sessions

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