



2025/2026 ANNUAL REPORT

**Team-based Care in Action: Highlights from
Edmonton Southside Primary Care Network**

Table of contents

01	About the Edmonton Southside Primary Care Network
02	Message from our Board Chair
03	Strengthening team-based care
04	Multidisciplinary team programs and services update
06	Helping patients get care sooner
07	Using data to improve care
08	Increasing access through outreach
09	Supporting safer transitions from hospital to home
10	Supporting patients mental health
11	Social connection as part of care
12	Financial statement summary

About the Edmonton Southside Primary Care Network

The Edmonton Southside Primary Care Network (ESPCN) was the first Primary Care Network in Alberta and, over the past 21 years, has grown to become the largest PCN in Edmonton. Our highly trained clinical and administrative staff each play an important role in improving, coordinating, and ensuring the delivery of primary health services to patients in the communities we serve.

Team-based care remains the foundation of ESPCN's work. This model helps patients access the right care at the right time, supports safer transitions from hospital to home, improves outcomes for people living with chronic conditions, and expands access to mental health and community supports.

Vision

The trusted cornerstone of a healthy community

Mission

To provide team-based primary care and work with our community to achieve the best health for all

Values

Respect, Passion,
Collaboration, Dedication,
Innovation



The ESPCN acknowledges that the traditional land on which we are located is in Treaty Six Territory. We would like to thank the diverse Indigenous Peoples whose ancestors' footsteps have marked this territory for centuries, such as nêhiyaw (Nay-hee-yow) / Cree, Dené (Deh-neyh), Anishinaabe (Ah-nish-in-ah-bay) / Ojibwe, Nakota Isga (Na-koh-tah ee-ska) / Nakota Sioux (Na-koh-tah sue), and Niitsitapi (Nit-si-tahp-ee) / Blackfoot peoples. We also acknowledge this as the Métis' (May-tee) homeland and the home of one of the largest communities of Inuit south of the 60th parallel. We respect the histories, languages, and cultures of First Nations, Metis, Inuit, and all First Peoples of Canada, whose presence continues to enrich our community.

Message from our Board Chair

This past year, the Edmonton Southside Primary Care Network continued to demonstrate the value of team-based primary care in action. As both Board Chair and a physician member of this network, I see every day how important it is for patients to be connected to a medical home that can respond to their needs with coordinated, timely, and patient-centred care.

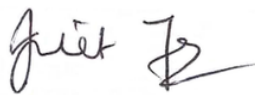
Across the report, you will see how ESPCN teams are strengthening care in many ways: integrating multidisciplinary team members within clinics, expanding access and increasing capacity for current and future programs through the Central ESPCN Clinic, supporting patients after hospital discharge, using data to improve chronic disease care, and helping patients access mental health, social work, nutrition, physical activity, and community-based supports.

This year also marked an important milestone with the addition of nurse practitioner members to the network. Their participation reflects the evolving ways primary care providers are working together to meet the needs of patients and communities.

A strong primary care system depends not only on clinical care, but also on the systems that support it. This year's work in proactive outreach, panel management, medical home optimization, and quality improvement reflects ESPCN's ongoing commitment to helping clinics identify care gaps, respond to patient needs, and improve care delivery across the network.

At the same time, primary care continues to operate within a changing health system. As the broader provincial model evolves, the Board remains focused on supporting stability, thoughtful adaptation, and the continued delivery of care that keeps patients, providers, and medical homes at the centre.

On behalf of the Board, I want to thank our physician and nurse practitioner members, staff, leadership, partners, and community supporters. The work highlighted in this report is made possible through your commitment to patients and to the continued strength of primary care on Edmonton's south side.



Juliet Fairfax

ESPCN Board of Directors 2025/26

Juliet Fairfax
Jade Lau
Freda Lo
Erin Park
Blake Pedersen
Nathan Turner
Dawn-Ellen Young
Fozia Zakaria

Strengthening team-based care

This year, ESPCN continued to expand and strengthen team-based care through our mainly decentralized model, which prioritizes integrating team members directly within the patient's medical home. This means patients can receive care from the right provider, at the right time, closer to where they already see their primary care provider. Every patient's needs are different. Support may include managing chronic conditions such as diabetes or mental health challenges, nutrition counselling, physical activity guidance, assistance navigating community resources, or follow-up after leaving the hospital.

ESPCN multidisciplinary teams include primary care registered nurses, behavioural health consultants, registered dietitians, exercise specialists, registered social workers, and nurse practitioners.

In 2025/26, ESPCN's 400+ members cared for 424,621 paneled patients, and 75.4% of member clinics had at least one integrated multidisciplinary team member. This year, ESPCN team members delivered care to 66,592 patients through 150,566 patient encounters.

ESPCN continued to grow this year with enrolment increasing by **3.75%** and membership increasing by **9%**



400+
members



424,621
paneled patients



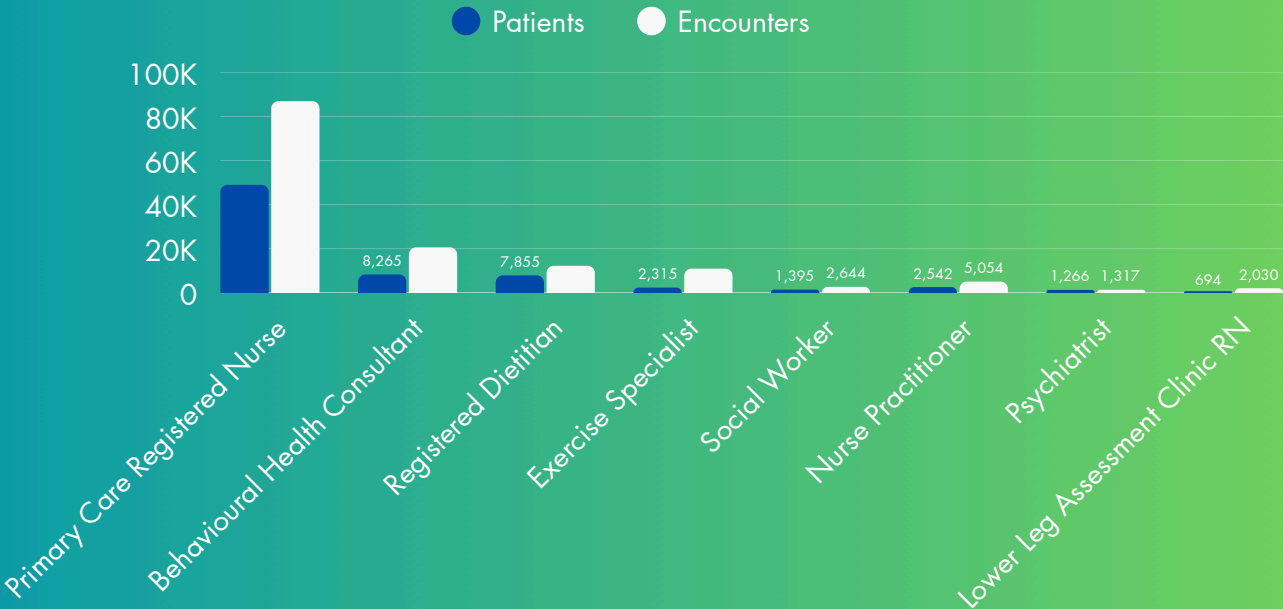
75%
of clinics had at
least one
integrated MDT



150,566
patient encounters
through ESPCN team
members

Patients and Encounters by MDT Role

2025/26



Multidisciplinary team programs and services

Nursing services

ESPCN employs both primary care registered nurses and nurse practitioners (PCRNs and NPs) who provide comprehensive nursing services and care to patients in primary care. They support patients across the lifespan, including pregnancy care, family health, disease prevention and health promotion, chronic disease management, and older adult care.

PCRNs help patients understand, manage, and improve their health through self-management support, education, nursing interventions and care coordination. NPs provide many primary care services independently, including assessing and diagnosing health concerns, ordering tests, prescribing medications, performing procedures, and referring patients to specialists when needed.

This last year, our nursing program focused on optimizing the primary care nursing role and scope. Initiatives include PCRNs transitioning from medical directives to nursing policies and procedures and collaborating with our quality improvement team to create a new nursing charting template that supports comprehensive patient care.



Mental health services

Behavioural health consultants (BHCs), usually a registered social worker, registered nurse, or registered psychiatric nurse, work to address mental health concerns through evidence-based behavioural interventions. BHC services aim to focus on symptom reduction, teaching self-management, and empowering the patient to be engaged in their own health.

In 2025/26, our BHCs and other team members participated in a mental health working group at the ESPCN to strengthen how BHCs support patients, clinics, and teams. This work included clarifying the BHC role, standardizing the BHC appointment structure, and offering education to support consistent, patient-centred mental health care. Additionally, ESPCN also continued work to support clinicians in caring for patients with mental health concerns, including developing a suicide prevention toolkit and related training.



Nutrition services

Registered dietitians (RDs) are uniquely trained to advise on food and nutrition for overall health and wellness. They are qualified to provide medical nutrition therapy for the prevention, delay, and management of disease.

This year, our RDs piloted the Mindful Eating Active Living program, a supportive six-week group focused on building healthier relationships with food, movement, and body image. Feedback was positive, and the program will continue to be part of the regular group program offerings. The team also worked with clinics to improve access to dietitian support for patients with specialized nutrition needs.



Physical activity services

Exercise specialists (ESs) help patients improve health, function, and quality of life through physical activity, exercise prescription, and self-management support. They support patients through education, individualized exercise prescription, self-management strategies, and recommendations to appropriate community resources and supports.

In 2025/26, the ES team focused on improving access to physical activity supports and helping patients build practical self-management strategies they can use long term. We continued to optimize group programming to better meet patient demand, including increasing the number of offerings for services such as GLA:D Hip and Knee and GLA:D Back. Updates to the Moving for Memory program aimed to make sessions more practical, engaging, and supportive for people experiencing memory changes.



Social work services

ESPCN social workers help patients connect with financial, housing, employment, and health services. They can provide guidance and education related to goals of care, personal directives, and enduring power of attorney documents. They also support patients and families to navigate health and social systems and advocate for them within those systems when required.

Over the last year, the social work team continued to build skills and strengthen services in primary care through primary care social work training and professional development. Additionally, the new Advance Care Planning workshop launched in May 2025, helping community members learn about important planning documents and connect with low-cost legal resources.



Helping patients get care sooner

Improving access to care remained a key focus this year. ESPCN worked to expand clinical capacity, improve appointment availability, and reduce missed appointments so patients could connect with care more easily.

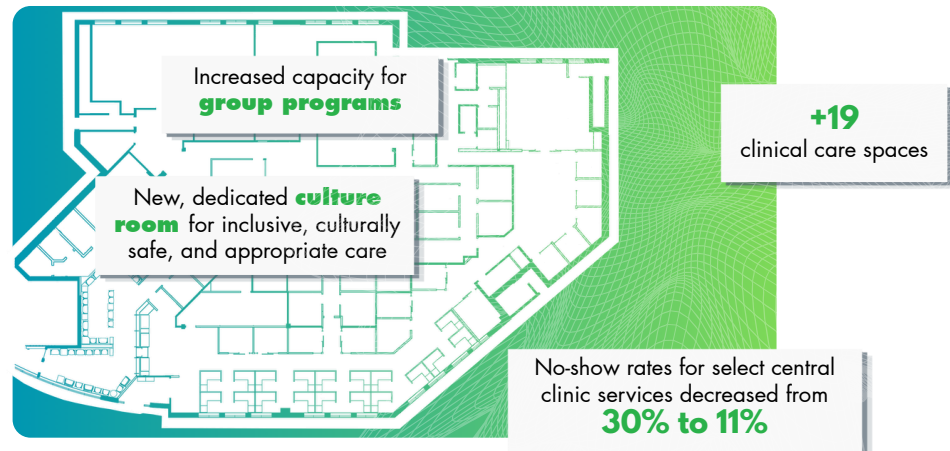
Central ESPCN Clinic improvements

In the summer of 2025, prompted by the growth in ESPCN members (an increase of 9%) and ESPCN's vision for the future of primary care, we initiated a renovation to expand the Central ESPCN Clinic to create more space for patient care. By moving administrative staff to a new second-floor office area, the main floor is now fully dedicated to clinical services.

The expansion added 19 clinical care spaces, increasing the total spaces to 27 (2 barrier-free exam rooms, 4 exam rooms, 17 consult rooms, and 4 virtual consult rooms). It also created additional capacity for group programs and has helped to reduce wait times for high-demand groups.

Process improvements within the clinical administrative team also reduced no-show rates for selected central clinic services from 30% to 11%.

The expansion also included the creation of a dedicated culture room, vented for smudging, to improve how the Central ESPCN Clinic enables inclusive and culturally safe and appropriate care.



Overall, the expansion of the Central ESPCN Clinic has substantially improved access, flexibility in appointment types, inclusivity, and culturally appropriate care.

Lower Leg Assessment Clinic

The Lower Leg Assessment Clinic continued to improve access to specialized lower leg care this year. Service enhancements increased referrals and helped patients receive timely assessment and treatment while staying connected to their medical home. The clinic also continued working with health care partners across Edmonton to strengthen care coordination and support better outcomes for patients with complex lower-leg conditions.

Central PCRN role expansion

Expanded central primary care registered nurse capacity helped improve access to nursing care for patients who did not have an integrated nurse in their clinic, while also supporting continuity of care during temporary staffing absences in member clinics.

Using data to improve care

Using data to guide improvement helps clinics provide more proactive, evidence-based care and ensures patients receive timely follow-up and support.

Behind the scenes, ESPCN supported clinics to use data and quality improvement tools to strengthen care and close gaps, particularly for patients with chronic conditions. The quality improvement team supported the use of the ESPCN Medical Home Optimization (MHO) toolkit, a resource to help medical home teams identify priorities, set clear goals, and make meaningful changes for patients. This year, 55 MHO projects were completed utilizing the MHO toolkit. Projects focused on diabetes, women's health, pediatrics, healthy aging, mental health, and chronic disease management.

Diabetes was a key focus area of medical home optimization projects, with improvements seen across several organization-wide diabetes indicators. Clinics saw clinically and statistically significant improvement in several target areas, including lower A1C levels, higher foot exam rates, increased A1C screening, and more comprehensive diabetes PCRN visits.

This year:



55 clinic improvement projects
were completed using the MHO toolkit



Screening increased from
89% to 91%



proportion of patients with uncontrolled
diabetes) decreased from **19% to 17%**



Annual foot exams increased from
8% to 10%

Listening to patients

Patient feedback helps ESPCN understand what is working well and where we can improve. This includes how easy it is to get care, how clearly providers explain information, and whether patients feel supported. Positive patient experience reflects trust, clear communication, and care that meets patients' needs.

This year, 1471 patients completed the patient experience survey at the Central ESPCN Clinic. Of those who completed the survey:



91%

rated their care as "excellent" or "very good"



97%

said their providers explained things in a way they could understand

For patients paneled to members with PCCA Support, outcomes in 2025/26 include:



of patients paneled to members with **PCCA support** were seen within three years



of **chronic disease management** patients were seen within one year



of patients **aged 75+** were seen within one year



The total number of patients directly supported **increased by 21%** (135,829 to 164,319)

Increasing access through outreach

Proactive care coordination assistants (PCCAs) are a key part of the quality improvement team. PCCAs support access to primary care providers by helping clinics identify and reach out to patients who may be overdue for screening, have not been seen for over one year, or require follow-up. This outreach helps reconnect patients with their medical home, supports timely preventive and chronic disease care, and ensures patients are directed back to the right provider at the right time. PCCA support to member clinics increased from 79% to 86%, meaning that PCCA services expanded from 77 to 82 member clinics.

Conflict rates also improved from 7.6% to 6.9%, below both zone and provincial rates. Conflicts exist when a patient is listed on multiple primary care providers' panels. Reducing conflicts helps clinics keep patient records accurate, avoid duplicate work, and ensure panel space reflects patients who are actively connected to each provider. PCCAs supported this work by calling patients, asking them to confirm who they considered their main provider, and updating provider lists.

Provincial recognition of innovation in primary care

In 2025, the Government of Alberta officially proclaimed November 10 as Proactive Care Coordination Day recognizing the growing impact of proactive care coordination across the province. The declaration acknowledges the ESPCN's leadership in developing and advancing the PCCA model, which helps identify and close care gaps, improve continuity of care, and ensure patients do not fall through the cracks. What began as an ESPCN initiative has since expanded to multiple Primary Care Networks throughout Alberta, supporting better access to preventive care and chronic disease follow-up for thousands of patients.

CII/CPAR

Helping patients stay connected to their medical home requires both proactive outreach and accurate patient attachment information. ESPCN supports clinics to strengthen panel identification, panel management processes, and continuity of care. This year, ESPCN clinics who had processes to confirm their active patient panels increased by 8.8%.

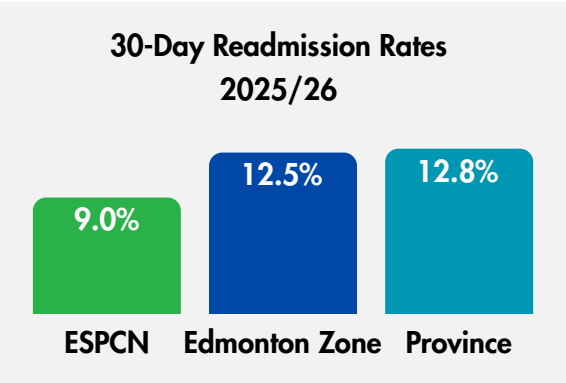
This year, ESPCN exceeded its CII/CPAR participation target, with 83% of eligible members enrolled. Together with PCCA outreach, this work strengthens continuity of care and supports patients in receiving care from the provider who knows them best.

Supporting safer transitions from hospital to home

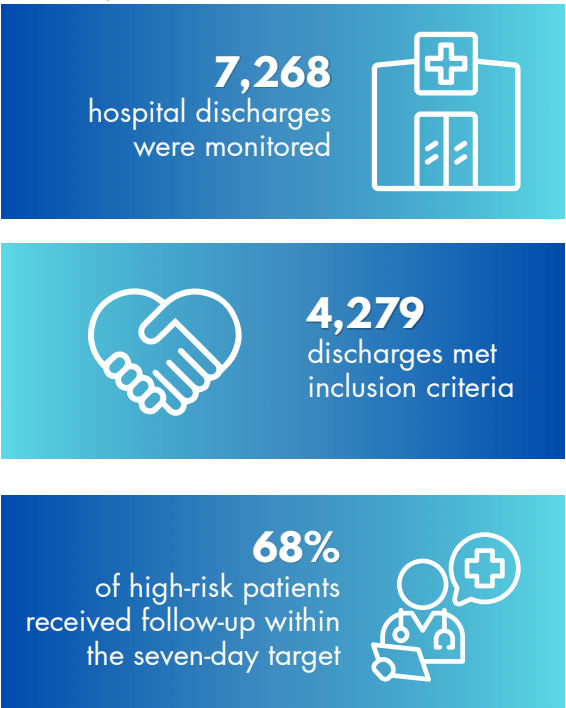
Primary care follow-up is an important way to reduce hospital readmissions. The ESPCN continues to deliver our Transitions of Care program to connect high-risk patients who have recently been discharged from hospital to primary care RNs and their clinic teams. Through this program, primary care registered nurses proactively contact recently discharged patients and help coordinate follow-up care with their primary care team. This program is an embedded process for ESPCN clinics and helps to strengthen complex care coordination within the medical home.

The days following hospital discharge are a vulnerable time for patients. Coordinated follow-up helps prevent complications, supports recovery, and reduces avoidable returns to hospital and emergency care.

ESPCN's 30-day hospital readmission rate was 9%, lower than both the Edmonton Zone (12.5%) and provincial averages (11.8% – 12.8%)

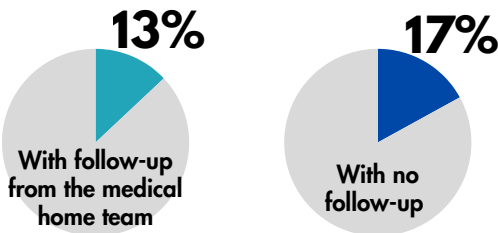


In 2025/26:

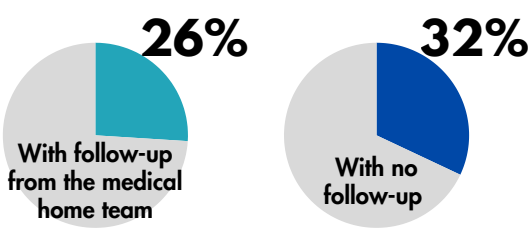


At ESPCN, high-risk patients who received seven-day follow-up had:

fewer hospital readmissions within 30 days



fewer emergency department visits



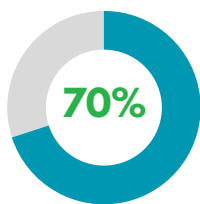
Supporting patients mental health

This year, ESPCN continued to help reduce barriers to mental health care through programs that connect patients with access to practical mental health support that help patients stay connected to care through their medical home.

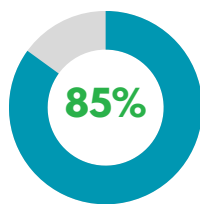
Reducing barriers to mental health support

The Supported Therapy Program helps people access counselling when cost or lack of benefits would otherwise make it difficult. Referrals to the Supported Therapy Program increased this year, averaging seven new referrals per week, resulting in over 2,300 counselling visits.

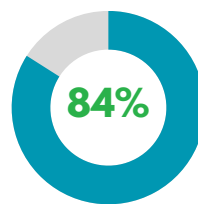
Patient experience surveys showed that:



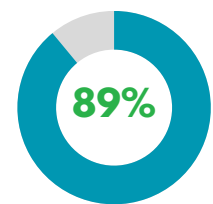
of participants said they would not have accessed therapy without the program



of participants reported gaining coping strategies



of participants felt more confident managing their mental health



of participants reported a positive overall impact

Specialized psychiatry consultations

Our Psych Linkages program helps patients access one-time psychiatry consultations through referrals from primary care providers. Demand for mental health support remained high this year. Through Psych Linkages, ESPCN received and managed 1,785 referrals while continuing to provide timely access to psychiatry consultations and supporting family physicians with expert guidance on diagnosis, medication, and treatment planning for a wide range of adult mental health concerns.

Social connection as part of care

To help improve the quality of life and encourage holistic care for patients, ESPCN continued to deliver programs that promote overall well-being. This includes access to workshops and group programming and continuing to create social connections that support isolated seniors.

Workshops and group programming

ESPCN offers six non-referral workshops (Changeways: Strategies for Personal Change, Emotional Regulation, Group Prenatal, Mindful Eating Active Living, Advance Care Planning, and Seniors' Centre Without Walls) and three referral-based group programs (GLA:D Back, GLA:D Hip and Knee, and Moving for Memory).

ESPCN group programming and self-referral workshops received exceptionally positive feedback this year. A total of 292 patients participated in feedback surveys for our group workshops, with nearly all participants reporting satisfaction and intent to use the strategies they learned. 99.3% of survey participants planned to use the supports and strategies presented in the class, and 98.9% said they would recommend the class to others.

Community connections

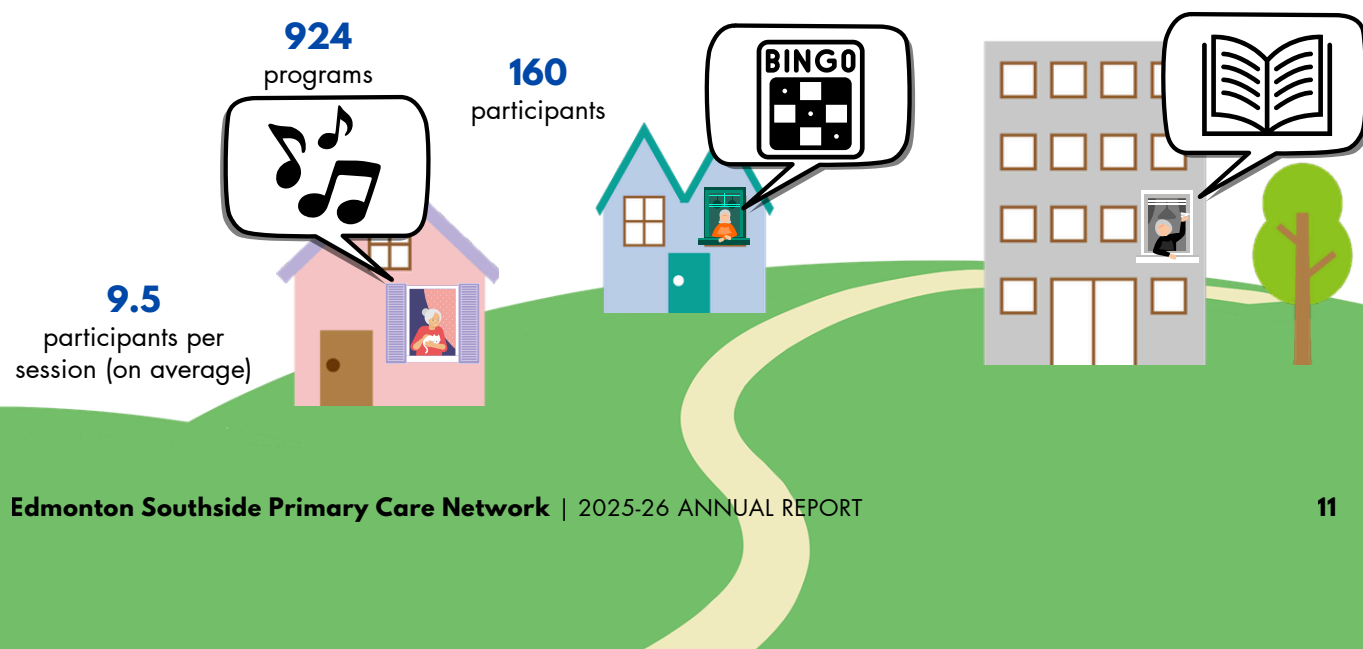
Seniors' Centre Without Walls (SCWW) is a free, phone-based health and wellness program designed to support socially isolated seniors. Participants can join from the comfort of their homes using just a telephone. In partnership with community organizations and other PCNs, SCWW delivers a range of wellness and recreational programming and accepts referrals from across the province.

The Seniors' Centre Without Walls program delivered:

- 924 phone-based programs
- 160 active participants
- An average attendance of 9.5 participants per session



Many participants reported experiencing isolation or loneliness at intake, highlighting the importance of accessible, community-based programming.



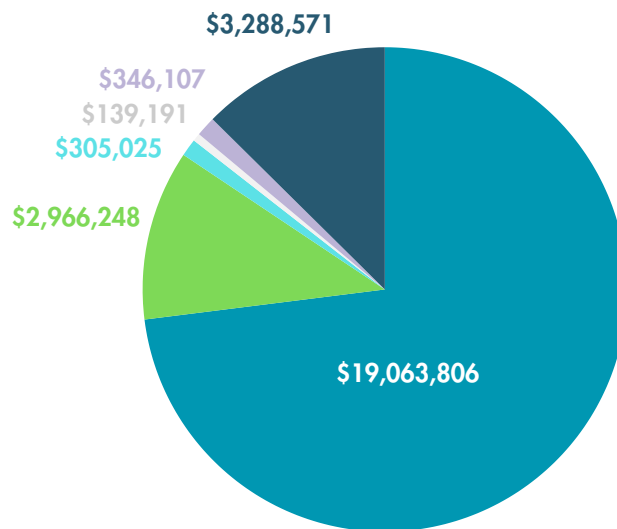
Financial statement summary

Statement of operations

	2026	2025
	\$	\$
Alberta Health Grant - Operating	25,622,901	24,107,045
Alberta Health Grant - Capital	368,983	648,809
Business Plan Amendment	81,914	928,073
Other Grants	35,150	34,428
	26,108,948	25,718,355
Advertising	11,545	6,342
Bank charges and fees	2,005	1,919
Catering expense	8,943	25,016
Contract services	255,548	205,563
Dues and subscriptions	251,226	218,284
Evaluation costs	94,486	97,858
Information technology	439,167	415,054
Insurance	60,830	57,798
Office and supplies	105,724	84,112
PAN PCN contributions	139,191	83,373
Payments to physicians	2,549,602	2,895,635
Professional development	105,487	89,523
Professional fees	39,267	56,666
Rent	678,198	557,721
Repairs and maintenance	13,319	21,621
Small equipment purchases	29,914	24,972
Supported therapy pilot	441,125	388,003
Telephone and communications	92,472	86,984
Travel	9,341	17,783
Wages and benefit		
Administration	2,026,015	1,980,355
Clinical support	4,459,081	4,415,865
Health professionals	13,927,479	13,339,099
	25,739,965	25,069,546
Excess of revenue over expenses before other items	368,983	648,809
Amortization of capital assets	(368,983)	(326,437)
Loss on disposal of capital assets		(322,372)
Excess of revenue over expenses for the year and net assets, end of the year	-	-

Expenses by priority initiative

- Clinical Supports and Services
- Medical Home Optimization
- Community Development
- Zonal Expenses
- PCN Support Program - Nurse Practitioner
- Central Allocations



Payments to physicians

	2026	2025
	\$	\$
Services ¹	113,884	169,191
Multidisciplinary team overhead payments	2,435,718	2,726,444
	2,549,602	2,895,635

¹ Services to Organization include Board honorariums, hourly remuneration for specific medical direction and management guidance, and payments to psychiatrists

Staffing summary

	2026		2025	
	FTE	\$	FTE	\$
Total Direct Care Provider Staffing	109.2	13,927,479	109.7	13,344,419
Total Clinical Support Staffing	40	4,459,081	41	4,415,865
Total Admin and Support Staffing	18	2,056,582	18.7	2,058,858
	167.2	20,443,141	169.4	19,819,142

The Statement of Operations and the Payments to Physicians was taken from Financial Statements audited by Kingston Ross Pasnak LLP