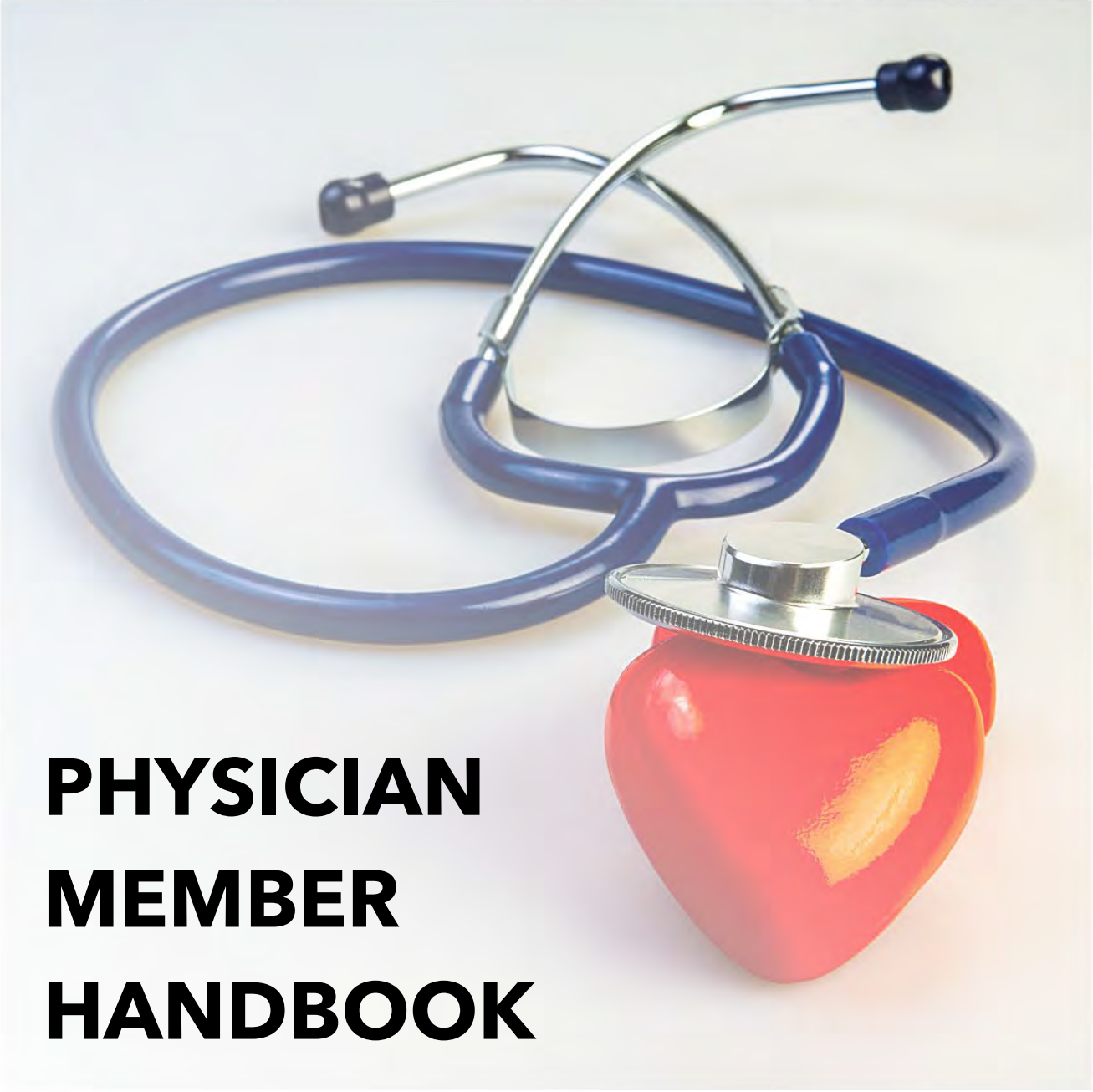
2022

Primary Care Network
EDMONTON SOUTHSIDE



PHYSICIAN MEMBER HANDBOOK

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WHAT IS A PCN?

Primary Care Networks (PCNs) are the most common model of team-based primary health care delivery in Alberta. PCNs are groups of doctors working together with teams of health care professionals, such as nurses, dietitians and behavioural health consultants, to meet the primary health care needs of people in their communities.

There are 40 PCNs operating across Alberta. About 80% of primary care physicians in Alberta are registered in a PCN. There are close to 3.8 million Albertans enrolled with a PCN.[1]

- Learn more about Primary Care Networks[2]
- Read the Primary Care Networks profiles[3]
- Read the Primary Care Networks review[4]

PCN GOVERNANCE

The Edmonton Southside Primary Care Network (ESPCN) is a publicly funded, not-for-profit corporation and exists to enhance the delivery of primary care. The ESPCN was established in May 2005 as Alberta's first primary care network and has a vision to be the trusted cornerstone of a healthy community.

Each Primary Care Network is created through a joint venture partnership between a physician Not-for-Profit Corporation (NPC) and Alberta Health Services (AHS). Each joint venture partner has specific and unique responsibilities to carry-out the objectives of the joint venture. The business of the NPC is managed under the direction of its Board. The Board delegates to the Executive Director (ED), the authority and responsibility for managing the everyday affairs of the NPC. Directors monitor governance and management on behalf of the NPC members.

Grant Agreement and Accountability

PCNs were originally governed by the trilateral agreement dated April 1, 2003, between Alberta Health (AH), the Alberta Medical Association (AMA), and Alberta Health Services (AHS) (Appendix 1). This Agreement expired March 31, 2011, and was replaced by successive, annual continuance grants from Alberta Health for the period April 2011 to May 2013, when the AMA finalized a new agreement with Alberta Health. The ESPCN has entered successive 3-year grant agreements with AH ever since.

[1] https://www.alberta.ca/primary-health-care.aspx
[2] https://pcnpmo.ca/alberta-pcns/Pages/default.aspx
[3] https://open.alberta.ca/dataset?q=%22Primary%20Care%20Network%20(PCN)%20Profiles%22
[4] https://open.alberta.ca/publications/primary-care-networks-review

The recent grants differ from the previous trilateral agreement grants. The new grant has established deliverables for the ESPCN based on the PCN Evolution Framework[5]. Notably, Schedule B to this Agreement describes system level and medical home indicators to which the ESPCN is held accountable.

PCN governance is provided through a Provincial PCN Committee that is chaired by Alberta Health (AH) and includes representatives from PCNs and Alberta Health Services (AHS). The committee provides advice to the ministry and sets direction for PCNs. In 2017 Alberta primary care physicians voted 88% in favour of moving to a five Zone Provincial Model. This structure allows PCNs to collaborate on service delivery priorities within each zone. The five Zone PCN Committees report to the Provincial PCN Committee (North, Edmonton, Central, Calgary and South Zones).

To provide more community-based health care closer to where Albertans live, the Zone PCN Committees assess the health needs of people in their catchment areas and create service plans to address gaps in health service delivery. Each Zone PCN Committee includes representatives from PCNs, AHS and local communities.

The Provincial and Zone PCN Committees are working to:

- Integrate and align health service delivery between PCNs, AHS and community-based organizations that also deliver health services
- Support standard and consistent delivery for Albertans across the province

Read the news release on the PCN governance framework[6]

PCN Board Governance Policy

The ESPCN has a governance connection between AHS and the PCN Board of Directors. Two AHS representatives and two appointed ESPCN Board of Directors form a joint governance committee that reviews major board decisions to ensure they align with good governance practice and AHS, and AH policy. The AMA's Accelerating Change Transformation Team (ACTT) provides board governance training[7] for physicians interested in learning more about the role that they play within PCNs.

The purpose of the PCN Board Governance Policy is to provide direction on board governance structure, roles and responsibilities and operational requirements. The intended

5 http://www.pcnevolution.ca/SiteCollectionDocuments/PCNe%20Overview/PCN%20Evolution%20Vision%20and%20Framework.lrg.pdf

6 https://www.alberta.ca/release.cfm?xID=47113957717F5-A4BC-34B1-AE8AC3BA047727F2

7 https://actt.albertadoctors.org/PMH/leadership/PCN-Governance-Training/Pages/default.aspx

outcome is effective, consistent, and accountable PCN governance and oversight. Full details of the policy can be found in the Primary Care Initiative (PCI) Policy Manual.[8]

Primary Care Initiative Committee (PCIC)

The Primary Care Initiative (PCI) Policy Manual (also referred to as the PCN Policy Manual) was developed by the Primary Care Initiative Committee (PCIC) to provide the foundation on which PCNs will be developed, implemented and evaluated. Policy and principles will be developed for those components where provincial direction is required to ensure that PCI objectives are achieved. It is understood that the PCI policy framework and associated guidelines will evolve as all parties learn from the initial phase. (See Appendix C)

PCN Enrolment

Article 7 of the PCI Policy Manual provides specific detail on formal and informal enrolment. The summarized enrolment policies include (see Appendix A for enrolment details):

- *Core providers are family physicians/general practitioners and other health care providers. They can initiate and maintain enrolments by providing services.*
- *A patient is informally enrolled with a PCN when they have had one or more encounters over the previous three-year period and has been assigned to a patient panel in accordance with the* ***four-cut funding*** *methodology:*
    - *(i) Patients whose encounters are with a single provider are assigned to the patient panel of that provider;*
    - *(ii) Patients not assigned to a panel after step (a) are assigned to the patient panel of the provider with whom they have had the most encounters;*
    - *(iii) Patients still not assigned to a panel after steps (a) and (b) are assigned to the patient panel of the provider who completed the last physical exam on that patient; and*
    - *(iv) Remaining patients are assigned to the patient panel of the provider with the last recorded encounter for that patient.*
- *Formal Enrolment includes an acknowledgement by the patient and the physician of an ongoing relationship which includes:*
    - *(i) The patient's commitment to seek primary care services from the physician and the PCN.*
    - *(ii) The physicians'/core providers' and the PCN's commitment to provide primary care services to the patient.*

[8] https://actt.albertadoctors.org/file/PCN%20Policy%20Manual.pdf

- *Patients should be fully informed of the services and programs provided by the PCN so they can make an informed choice and understand the mutual obligations associated with formal enrolment.*

PCN Funding

Article 9 of the PCI Policy Manual outlines the enrolment rules and the payment to the PCN of $62 per annum for each patient on the enrolment list. The following is a highlight of the General Per-Capita Funding Policy (see full details in Appendix B):

PCNs operate on a three-year business cycle in which PCI monies will be used to:

- *Support patients and providers*
- *Provide incentives to expand the comprehensiveness of an existing service or fill service gaps*

At the local level, each PCN will determine how PCI monies will be allocated based on the application of approved principles and the approved business plan.

See PCN Policies in Appendix D.

PCN Objectives

PCN objectives are established by an agreement between AH, the AMA and AHS and were last revised in April 2017. The provincial objectives of AH and the AMA are:

1. **Accountable and Effective Governance -** Establish clear and effective governance roles, structures and processes that support shared accountability and the evolution of primary healthcare delivery.
2. **Strong Partnerships and Transitions of Care -** Coordinate, integrate and partner with health services and other social services across the continuum of care.
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.
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.

PATIENT'S MEDICAL HOME

Patient's Medical Home Definition

The ESPCN uses the definition of the Patient's Medical Home that has been developed by the College of Family Physicians of Canada (CFPC) and shared by the AMA. In Canada, the medical home model is advocated by the CFPC.

In Alberta, PCN Evolution is structured with the PMH model as its foundation

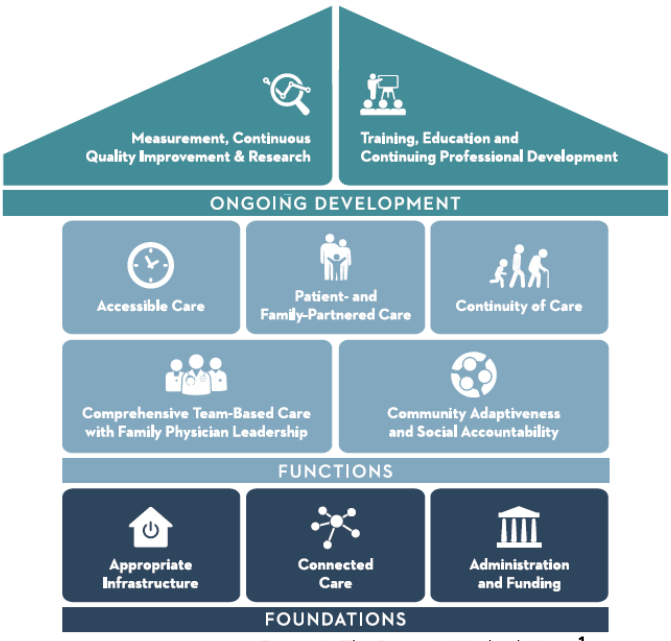


Figure 1. The Patient's Medical Home [1]

The PMH is a family practice defined by its patients as the place they feel most comfortable to discuss their personal and family health concerns. The goal is to have the patient's family physician, the most responsible provider of their medical care, work collaboratively with a team of health professionals, which may include nurses, pharmacists, dietitians and others as required, to coordinate comprehensive healthcare services and ensure continuity of patient care. These professionals can be located in the same physical site as the family physician or linked through different practice sites, telehealth or other enabling communications. The PMH enables the best possible outcomes for each person, the practice population and the community being served. [9]

Framework for the Patient's Medical Home

Becoming a PMH means the family physician and team commit to changing the way the care is delivered in pursuit of continual improvement supported by appropriate funding and infrastructure. The AMA has articulated the principles of the Patient's Medical into the following implementation elements. [10]

[9] https://www.albertadoctors.org/leaders-partners/innovation-in-primary-care/patients-medical-home
[10] https://actt.albertadoctors.org/file/overview-of-the-pmh.pdf

Coordinated Care

Patient's medical home:

- **aligns care** between specialists, hospital, community services, and others

Access to Care

(and information)

- when the patient wants or needs it

Patient Centred

- Care that focuses on the **whole person**
- Patients and families are **partners in care**

Organized Evidence-Based Care

- embeds **evidence-based guidelines** into daily practice

Team Based Care

- Multi-disciplinary teams
- Wrap-around patient care

Panel & Continuity

- patients see the **same provider and care team** whenever possible

Capacity for Improvement

- committed to **evidence-based medicine**
- **responsive** to patient feedback

Engaged Leadership

- provides **resources and tools** to support transformation
- **removes barriers**

Why Physicians Are Interested in the Patient's Medical Home?

In one word, change. The health and social needs of patients and communities are changing. The health system itself also continually evolves to meet new demands. The health workforce, including professional and support staff have changing responsibilities and capabilities. Physicians themselves have changing expectations of their role in providing care to patients.[11]

The PMH helps physicians to:

- Organize and prioritize activities to best meet the needs of their patients in this complex ever changing healthcare environment.
- Deliver the care that they want to deliver, practice with less stress, and develop deeper relationships with their patients and communities.
- Better adapt to the system that is changing around them.

ESPCN MODEL

The ESPCN is a publicly funded, not-for-profit corporation (NPC) and exists to enhance the delivery of primary care. Physicians comprise the membership of the NPC and membership is voluntary. The ESPCN was established in May 2005 as Alberta's first PCN and has a vision to be the trusted cornerstone of a healthy community. Today, there are over 300 physician members and over 100 primary care practices attached to the ESPCN.

ESPCN Governance

Board of Directors Membership Requirements

PCNs are governed by an elected Board of Directors (BOD) and as laid out in the ESPCN Articles of Association, 12.2, "The BOD must consist of not less than five or nor more than 12 directors. Any physician member in good standing in the Company is eligible for election as a director." The ESPCN strives to ensure diversity, when possible, on its Board of Directors, in addition to ensuring varied knowledge backgrounds in order to be as comprehensive as possible. To complement broad governance expertise, two independent directors serve on the board and are nominated by acclamation. Members of the NPC are elected to the BOD during the Annual General Meeting. Terms on the Board last 3 years. Board members are able to be re-elected, but may only serve for a maximum of 3 consecutive terms. (Articles of Association, 12.5).

[11] https://actt.albertadoctors.org/PMH/Pages/Why-PMH-and-Getting-Started.aspx

The BOD are subject to the provisions of the Companies Act and the Articles of Association for 1157178 Alberta Ltd. (also known as the ESPCN). The BOD is responsible for:

- Managing or supervising the management of the business and affairs of the PCN;
- Establishing policies;
- And exercising all powers of the company (Articles of Association, 15.3.).

The BOD meets on a bi-monthly basis or as required. Directors are required to attend these meetings. The Board also has four standing sub-committees that directors are required to participate in. These are the Finance & Audit Committee, the Governance Committee, the HR & Compensation Committee, and the Nominations Committee. Ad Hoc committees are formed as needed.

Annual General Meeting

The membership is invited to the Annual General Meeting (AGM), which is typically held in June each year. The purpose of the AGM is to undertake a number of activities, which include:

1. To present for approval the minutes of the previous AGM
2. To receive the report of the Chair, Board of Directors, on behalf of the ESPCN
3. To receive and consider the annual audited financial statements of the ESPCN for the fiscal year ending and the auditor's report thereon
4. To appoint auditors for the ensuing year
5. To elect individuals to the Board of Directors

In order to complete the business activities at an AGM, quorum must be met. Quorum shall be at least 25% of the members entitled to vote.

Eligibility to Vote

(a) Each Member shall have the right to one (1) vote on each matter voted on at a General Meeting, if the Member:

  (i) Has been a Member in good standing for at least one (1) month immediately prior to the date of the meeting; and
  (ii) Is not a paid employee of the Company when the vote is cast

(b) Votes may be given either personally or by proxy[12]

[12] ESPCN/NPC Articles of Association

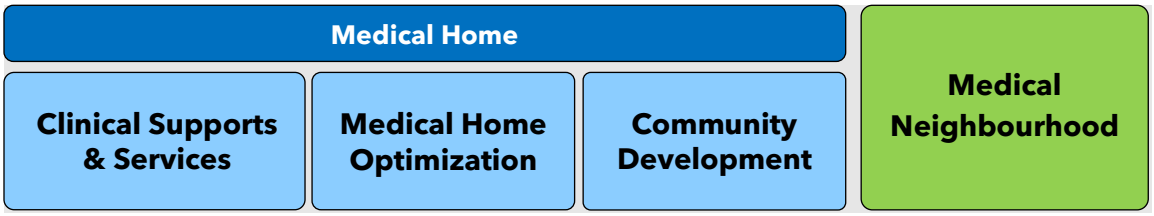
BUSINESS PLANNING & CORPORATE BUDGET

Business Planning

The ESPCN enhances the delivery of primary care by contributing to the Patient's Medical Home and fostering the community resources that contribute to individual well-being.

The Medical Neighbourhood and Patient's Medical Home are visions for an inter-connected, collaborative primary care system extending from a family medicine practice that recognizes the important contributions that social and community supports have on the health of the population.

For the 2021 to 2024 Business Plan, the ESPCN will operate in four priority areas:



Clinical Services and Supports

The ESPCN's multidisciplinary team (MDT) is a key piece of the Patient's Medical Home. The MDT contributes to improved access and continuity of care at the clinics and supports the delivery of comprehensive care specific to the patients' needs.

Medical Home Optimization

The ESPCN will help our members with the continued advancement of the Patient's Medical Home. The College of Family Physicians of Canada considers measurement, quality improvement, research, training, education and professional development to be indicative of a commitment to ongoing development.

Community Development

The ESPCN will strengthen the connections and relationships between social and community agencies and work towards our common goal of healthy communities. The ESPCN will identify, develop and capitalize on community resources that can benefit the patient population cared for by member physicians and the clinical team.

Medical Neighbourhood

The Medical Neighbourhood is the community that interconnects and surrounds individuals and contributes to their well-being. It includes other PCNs, all AHS in-patient and community services, specialty medical services and community agencies. The ESPCN will collaborate

with these agencies to integrate and align care to improve the experience and results for the population. The Edmonton Zone (EZ) PCNs and AHS have agreed upon the Medical Neighbourhood initiative as the common framework to work together.

This image shows how the ESPCN approaches the patient's medical home, medical neighbourhood and supports healthy communities.

Corporate Budgeting

Yearly Budgeting

The ESPCN's fiscal year runs from April 1 to March 31 and the ESPCN's official budget is due to AH at the end of March. Budgeting begins in October and an early draft is presented at the January board meeting. Each year, AH requires that the PCN use panel numbers released in late February as the basis for the revenue for the subsequent year's budget. A finalized budget is presented to the Finance and Audit Committee and the Board in the month of March.

Business Plan Budgeting

As a requirement by AH, PCNs submit a yearly official budget, as well as budgeting that coincides with the priority initiatives and objectives outlined in the business plan. The business plan budget numbers are high-level in comparison to the yearly budget which is refined and detailed. The amounts are subject to be adjusted based on panel numbers from year-to-year.

ESPCN policies are available by request through your Primary Care Manager.

- ESPCN Financial Policy - 2019-01-06
- Investment Policy
- Physician Membership Policy
- Payments to Member Clinics – Rev. Mar. 16, 2016 Policy
- Payments to Physicians for MDT Care & Overhead Policy
- Physician Compact Final - 2016-05-31

PHYSICIAN MEMBERSHIP

Board Approval Process

All new physician membership applicants are required to fill out a membership application package. These are reviewed at a joint BOD and Governance Committee meeting for potential approval. Once approved, documentation is then sent to AH to register the physician to a specific PCN. Only family physicians and pediatricians are eligible to be members of PCNs in Alberta.

To ensure alignment with the ESPCN's business plan, all new applicants must sign an Information Management Agreement (IMA), a business plan amendment (BPA), a letter of participation (LOP), an Alberta Health Physician Consent form (AHPC), and a Physician/Clinic Application with demographic and contact information. Applicants must also be members in good standing with the College of Physicians and Surgeons of Alberta (CPSA). New clinics are required to ensure they have a Privacy Impact Assessment (PIA) in place and provide the ESPCN with their facility ID, their professional and clinic communication information, hours of operation, EMR type, and other demographic information that will assist the ESPCN in optimizing its service provision to clinics, physicians and patients.

Practice ID and Facility Code Number

The Practice ID is required by AH to align a physician's membership with a PCN. This ensures the PCN receives funding ($62 per patient) for that physician's panel as determined by AH. PCNs receive adjustments semi-annually to their funding based on these panel numbers. These panel numbers (or aggregated panel numbers for a clinic) determine the level of financial support the ESPCN can provide through the integration of a multidisciplinary team in a clinic's medical home.

Physicians often notice the panel numbers determined by AH are different from what they perceive their patient panel numbers to be. This, in part, is due to the 4-cut method AH uses for patient attachment mentioned above.

Joining a PCN

All PCNs have their own yearly budgets and business plan models, as determined by their physician membership and their BOD. Budgets are created and submitted for approval to AH on an annual basis. Business plans are registered and approved by AH on a three-year cycle. The oversight by AH of the budget and business plan cycles ensures that the public funding provided is used as intended to support the optimization of the patient's medical home.

When a physician signs the business plan approval form, they are demonstrating their agreement to participate in the three-year business plan for a particular PCN.

Moving PCNs

Sometimes a physician moves within Alberta, opens their own practice or joins another clinic. When this happens, their new location could mean that the physicians might want to join another PCN (i.e. a new clinic in another part of the city, possible population-based advantages, etc.). If it is determined by the physician that it would be better to join another PCN, then they have to "end-date" with their current PCN before they can join another. A physician can only be a member of one PCN at a time.

When a physician moves from one PCN to another, their complete panel does not transfer over all at once. A physician's complete panel will take up to three years to transfer to the new PCN. This AH regulation ensures ongoing continuity of care for the patients of a physician's former clinic, while also ensuring support for patient care at a new clinic. Physicians need to be aware of how this will potentially impact patient care in their medical homes.

Joining the ESPCN from another PCN

If a physician is leaving a PCN and wishes to join the ESPCN they need to do the following:

1. Connect with their current PCN's Executive Director or designated personnel to request to be end-dated.
    - ***Important Note:*** *Some PCNs accept verbal end-dating requests from physicians, most want something in writing, and for many even an email will suffice. However, a physician must check with the PCN they are leaving to determine the correct protocol.*

2. The PCN who has received the request for end-dating needs to formally acknowledge this request. This form, called "Change to Physician Group Information, AH2208" is then submitted to AH ending the connection of that physician's membership with that particular PCN. Once AH acknowledges the physician's request to no longer belong to a specific PCN, that physician is then free to join any other PCN of their choosing.

- ***Important Note:*** *This process is completed properly and in a timely manner. Otherwise the new PCN the physician wishes to join will not receive any financial support, even if it is a prorated amount based on the three-year funding transition model.*

Leaving the ESPCN for another PCN

If a physician is a member of the ESPCN and wishes to join another PCN:

1. Connect with your designated ESPCN Primary Care Manager and the Executive Director to request being end-dated.

2. The ESPCN's Articles of Association (5.1) state:

    - Any member may at any time upon ninety (90) days' notice withdraw their membership in the company:
        - By written notice to the Board to that effect; or
        - By verbal notice confirmed by a Board Minute
    - The physician needs to connect with the Executive Director of the ESPCN by some written means such as a letter or an email.
    - Once a physician member has been end-dated they are not entitled to any membership privileges.
    - If a physician member end-dates/terminates their membership, and decides they wish to rejoin the ESPCN they can reapply for membership, providing they are not a member of another PCN.

Membership Termination by the Board of Directors

If the relationship between a physician or clinic and the ESPCN is deemed to be non-functional, the BOD in the Articles of Association (5.2) reserves the right to end physician memberships as follows:

> *"The Board may terminate the membership of any member by a resolution of the Board. The member affected shall be notified in writing of a pending action and shall be given the opportunity of making representation before the Board prior to the Board's resolution to terminate the membership."*

ESPCN TEAM

Leadership

The ESPCN leadership team is a strong and dedicated group of professionals that support the physician members and ESPCN staff to deliver care to the community.

Executive Director (ED) oversees ESPCN operations, strategy and business planning, assists with the corporate budget, and makes recommendations to the BOD regarding program planning and goal setting.

Medical Director (MD) works in a dyad relationship with the Executive Director, and is responsible for providing clinical leadership in ESPCN programming and primary care service delivery and acts as a representative for the ESPCN in the local medical community.

Clinical Director (CD) provides leadership, strategic direction, and operational direction for the clinical workforce, as well as the central ESPCN office and QI team. The CD also works with physicians and other health system partners and community agencies (i.e. AHS and Edmonton Zone PCNs) on the integration of services and partnership initiatives.

Primary Care Managers (PCMs) oversee the management of the ESPCN MDT in the member's clinics. PCMs are the main point of contact for physicians and their clinics. One of the ESPCN PCMs oversees the Central ESPCN office and acts as the ESPCN Privacy Officer also.

Human Resources Manager (HRM) leads the ESPCN HR team and corporate practice to provide an employee-oriented; high-performance culture that emphasizes empowerment, quality, productivity, standards, goal attainment, and the recruitment and ongoing development of a superior workforce.

Quality Improvement Manager (QIM) provides leadership, strategic direction, and oversight to the Quality Improvement (QI) team to advance Patient's Medical Home initiatives throughout the PCN. The QI team (Improvement Facilitators, EMR Consultants and Panel Management Assistants) oversees the advancement of Medical Home initiatives throughout the PCN.

Evaluation Manager is responsible for the development, coordination, completion, and reporting of clinical evaluation projects and performance monitoring in the PCN.

Finance and Administration Manager is responsible for the design, integrity and performance of the corporation's financial system, and are experts in corporate accounting.

Central Office Administrative Lead (COAL) is responsible for the day-to-day administrative support operations at the PCN office and is the 'go to person' for all inquiries related to central office operations.

ESPCN Staff

The ESPCN employs medical professionals who work with family physicians to improve health outcomes of our patients. Our team of healthcare providers each play a specific role in improving, coordinating and delivering primary health services. Our primary care teams are composed of registered nurses, nurse practitioners, behavioural health consultants, registered dietitians, respiratory therapists, exercise specialists and social workers.

Our clinical staff are supported by a diverse administrative team out of the Central Office including scheduling and reception, data management, referral coordination and group programming.

Further corporate functioning of the PCN is supported by our dedicated Administrative Assistants and Coordinators, Community Development and Partnerships team, Communications team, Finance and Administration team and Human Resources team.

Staff Diversity

ESPCN staff come from many cultural backgrounds and speak over 20 different languages, which in turn helps us serve our diverse patient population.

All voices are needed when we pursue the diverse ideas and perspectives that allow us to serve our patients respectfully and with dignity. The ESPCN is dedicated to achieving a more diverse, equitable, accessible and inclusive environment for all of our employees that supports our role in improving, coordinating and delivering primary health services. We are committed to a working environment free from discrimination, bullying, or harassment. Equity, diversity, and inclusivity is reflected in recruitment, retention and advancement of our employees. ESPCN staff are provided the training and skills to prepare for work in a diverse environment, and to have the knowledge and skills to contribute to equity and inclusivity.

Human Resources

The ESPCN has a decentralized staffing model. While ESPCN staff work mainly in primary care physician clinics, they are hired and employed by the ESPCN, and report directly to ESPCN Primary Care Managers. Physicians and/or clinic management may have input in the hiring process for our clinical staff when that staff member will be predominantly assigned to one clinic.

The ESPCN has set hours of operation for its central office. We are open from 8:00 a.m. to 5:00 p.m. Monday to Thursday and from 8:00 a.m. to 4:30 p.m. on Fridays. The ESPCN

prefers clinic staff to work within these hours as much as possible to ensure management and administrative support is available to staff during their working hours.

Time Off:

Staff are required to attend monthly staff meetings, as well as discipline-specific meetings. This ensures our staff remain connected with the ESPCN, as well as their disciplines. The ESPCN believes that professional development opportunities are necessary for all employees to achieve excellence in their professional employment. To that end, the ESPCN provides paid time off for staff to attend professional development opportunities that are applicable to their profession. ESPCN staff are required to advise their clinic(s) of any upcoming absences.

ESPCN staff may require the following time out of clinic, supported by the ESPCN HR policies and procedures:

- New Hire Orientation period and subsequent clinic/discipline-specific training
- ESPCN Staff Meetings: one ½-day per month and ad hoc when required
- Education
    - Professional Development hours (5 paid days per year, prorated for FTE, available after 1 year of employment)
    - Annual Education (1/2 day per year)
    - Annual CPR recertification (1/2 day per year)
- Vacation, Personal, and Sick Days (number varies based on years of service, FTE and level of experience)
- Statutory holidays
- Monthly 1:1 meetings (staff member and their manager) and quarterly MDT huddles (clinic teams)
- Committee meeting time (time requirement varies). ESPCN staff are encouraged to participate in ESPCN or external committees as appropriate for their role
- Extended leaves - addressed and granted by ESPCN management on a case-by-case basis (maternity/parental, short or long term-disability, caregiver, etc.)
    - There is no guarantee of the same staff member returning to the clinic after a leave
    - Clinics cannot elect to keep a temporary employee if a permanent employee is returning

The ESPCN has policies and procedures that all staff must adhere to. If a conflict exists between an ESPCN policy and a clinic policy, then these will be addressed with the physicians and Primary Care Manager. We encourage physicians and clinic teams to share feedback about integrated PCN staff on a regular and ongoing basis. Physicians should contact their Primary Care Manager if there are any concerns with an ESPCN employee to ensure that the concern is addressed in a timely fashion.

Quality Improvement (QI) Team

- **Improvement Facilitators (IF)** facilitate quality improvement meetings, support clinic teams to set new processes and goals, and assist in measurement, spread and scale of improvement efforts. The IF has an ongoing, continuous relationship with physicians and clinics.
- **EMR Consultants (EMR-C)** help clinic teams optimize their EMRs by building queries, templates, and automated notifications. EMR-Cs work with clinics on an ad hoc, as needed basis for time-limited support.
- **Panel Management Assistants (PMA)** work in clinics, maintaining panels, updating EMRs, identifying patients requiring screening and follow-up, and collecting data related to screening, panel, and patient access. Depending on the size and needs of the panel we, have two types of PMA support that is offered:
    - **Rotating PMAs** visit the clinic for 1-2 weeks blocks on a 6–12-week rotation. These PMAs are able to support the clinic to maintain their panel and engage in panel outreach for preventative health screening and clinical indicators.
    - **Fixed PMA** are assigned within a clinic on an ongoing basis. This type of PMA is a good fit for clinics with very large panels and many physicians who are involved in outreach and ongoing special projects.

Multidisciplinary Team (MDT)

Over the past 17 years, the ESPCN has grown to become the largest PCN in Edmonton and consists of a team of health care professionals who are passionate about creating healthier communities. Each member of our team of healthcare providers plays a specific role in improving, coordinating and delivering primary health services. Patients should be able access the majority of the care they need to meet their health goals within or connected to their medical home (or family physician's office). We strive to meet this goal through an MDT team working with family physicians.

Team-based care is supported by the ESPCN through the hiring, management, and support of the following MDT: Registered Nurse (RN), Nurse Practitioner (NP), Exercise Specialist (ES),

Registered Dietitian (RD), Respiratory Therapist (RT), Behavioural Health Consultant (BHC - may be a Nurse or Social Worker), Social Worker (SW), and Occupational Therapist (OT - lower leg clinic only). Talk to your Primary Care Manager about accessing the Psychiatry Linkages Program.

The goal for the ESPCN MDT is to have all disciplines working to their full scope and ensuring the right provider is being utilized at the right time. To ensure the best use of the MDT, we strive for:

- Co-locating clinicians in the clinic wherever possible to foster relationship building and optimize team work.
- Utilizing central services referral if the clinic does not have a co-located MDT in their clinic (See Appendix E: Central Referral Form).
    - Read more about Central Office Services
- Clinicians functioning to full scope of practice (See Appendix F: MDT Full Scope Listing)

Primary Care Managers, in discussion with physician members and based on patient panel needs, determine which team members will be co-located into clinics.

- Special needs are considered, e.g., maternity, geriatrics, spoken language, etc.
- As the employer, the ESPCN may need to reassign current MDT to your clinic, i.e., clinic closure; however, if a new hire is being considered, physicians/clinics may participate in the interview process if desired

The ESPCN does not hire positions (MOAs, referral coordinators, LPNs, etc.) that, prior to PCNs inception in Alberta, were already part of a clinic's staffing complement. Rather, PCNs were developed to address gaps in the MDT to better enable comprehensive, team-based care. ESPCN staff also participate in PCN directed work such as:

- Transitions of Care, which is an initiative that monitors for high-risk hospital discharges and intervening along with physician to reduce readmission (See Appendix I),
- Facilitation of patient education groups[13],
- Monthly PCN staff/discipline meetings,
- Ad hoc working groups/projects,
- Home visits.

[13] https://www.edmontonsouthsidepcn.ca/workshops/

MDT Utilization

ESPCN staff complete brief encounter records for each patient visit. This enables the PCN to review activity of health care providers, calculate the number of patients seen, patient access to care, no show rates and types of visits. This information is then used to produce utilization reports that can inform resource allocation and identify opportunities to improve care. An overview of MDT Utilization Reporting can be found in Appendix J.

Primary Care Managers and physician members review this data twice a year to ensure clinicians are well utilized, functioning to full scope, as well as to help determine FTE needed to support the panel (within the ESPCN resource allocation approach). Often new clinics start by referring patients to the ESPCN central office providers (See Appendix E). Using this data helps to establish which discipline is in most demand. If there is less than 70% utilization and/or a >30% no show rate in 3 out of 6 months, this triggers utilization support measures (Primary Care Manager and Clinical Educator). If a clinic is still not meeting targets after utilization support has been implemented, the MDT provider may be removed from the clinic or the FTE may be reduced to ensure good stewardship of resources.

MDT Allocation

Every six months, the ESPCN receives a panel calculation from Alberta Health based on the 4-cut method. The ESPCN receives $62 dollars per patient per year. A portion of this amount is allocated to the physician clinic for the MDT assigned to that clinic and MDT overhead

support. The remaining amount covers all ESPCN central programming and administrative costs (office rental, manager salaries, administration, QI team, etc.).

Physician clinics are placed into bands of 800 based on the patient panels as reported AH. The band in which a clinic falls into will determine how much MDT FTE will be dedicated to support patient care and support for Medical Homes. The *table below* outlines the FTE breakdown of each band.

Primary Care Managers, in discussion with physician members and based on patient panel needs, determine which team members are co-located in clinics. Talk to your Primary Care Manager about what your clinic is eligible to receive.

For clinics with less than 800 panel enrollees, PCN central services (RN, RT, BHC, SW, RD, ES) and PMH support including access to QI resources, panel management and outreach support are available. An assigned Primary Care Manager, who will be your liaison, will also be available.

Resource Allocation Bands

	Lower Limit	FTE Support	Additional FTE if MDTOH Forfeited
Band 1	0-799	0	-
Band 2	800-1,599	0.2	0
Band 3	1,600-2,399	0.4	0.2
Band 4	2,400-3,199	0.6	0.2
Band 5	3,200-3,999	0.8	0.2
Band 6	4,000-4,799	1.0	0.4
Band 7	4,800-5,599	1.2	0.4
Band 8	5,600-6,399	1.4	0.4
Band 9	6,400-7,199	1.6	0.4
Band 10	7,200-7,999	1.8	0.6
Band 11	8,000-8,799	2.0	0.6
Band 12	8,800-9,599	2.2	0.6
Band 13	9,600-10,399	2.4	0.8
Band 14	10,400-11,199	2.6	0.8
Band 15	11,200-11,999	2.8	0.8
Band 16	12,000-12,799	3.0	1.0
Band 17	12,800-13,599	3.2	1.0
Band 18	13,600-14,399	3.4	1.0
Band 19	14,400-15,199	3.6	1.2
Band 20	15,200-15,999	3.8	1.2
Band 21	16,000-16,799	4.0	1.2
Band 22	16,800-17,599	4.2	1.2
Band 23	17,600-18,399	4.4	1.4
Band 24	18,400-19,199	4.6	1.4
Band 25	19,200-19,999	4.8	1.4

New physicians receive in-clinic supports based on AH determined panel size once the ESPCN receives this number at the next semi-annual period. For example, if a physician signs up after the AH cut-off date for the semi-annual period, the ESPCN does not receive that physician's panel funding until the following six-month period. Cut-offs are determined by AH, but usually occur mid-January and mid-August.

What happens if you move clinics? (See also: Moving PCNs)

- Multi-physician practice: physician panel can be moved from one ESPCN clinic to another at the same times the PCN receives panel numbers from Alberta Health.
- Cut offs for physicians to notify ESPCN of a clinic move are March 31 and September 30
- Solo physician practice: the panel can be moved at the time of physician relocation
- If the physician is joining a practice that belongs to another PCN, they can choose to stay with the ESPCN or end date and join the other PCN
- The MDT staff and MDTOH follow the panel funding

MDT Overhead (MDTOH)

The Multidisciplinary Team Overhead (MDTOH) is a payment intended to support the overhead costs associated with having ESPCN clinical staff in the PMH and is provided by the ESPCN to member physicians.

The current monthly MDTOH payment is $3200 per 1.0FTE of MDT (clinicians), per month. There is no MDTOH payment attached to QI supports, including PMAs.

- One payment is made per clinic. Member physicians in a clinic must agree which entity will receive this payment.
- The ESPCN requests electronic payment information for ease of payment processing.
- Clinics may choose to waive their MDTOH in order to secure additional clinician FTE based on the respective resource allocation bands mentioned above.

Inclusions & Exclusions

The MDTOH includes coverage for cost of use of specific, dedicated space for the MDT and access to clinic administration supports, such as MOAs and referral management. There is an option for clinics to convert their regular MDTOH payment to increase the FTE resources that their clinic is allocated in order to increase clinical support. If a clinic elects to forego MDTOH, they are still required to provide dedicated space for the MDT and access to administration supports. Changes to MDTOH will be for the whole value of the month. Talk to your Primary Care Manager to determine your eligibility to forego MDTOH.

The ESPCN will provide necessary equipment and reimbursement for costs associated with initial set-up (if not already existing in the designated ESPCN space) of a MDT provider in a

member physician clinic. Equipment purchased for use in the clinic remains an asset of the ESPCN (an asset tag may be applied) and must be returned if the physicians choose not to remain members of the ESPCN. Physicians may provide input into the type of equipment purchased in terms of style, brand, etc. however, those requests will be considered in the context of what is reasonably provided to all ESPCN clinics. The following are examples of initial set up costs that will be covered by the ESPCN:

- IT equipment - computer, printer (option 1: ESPCN-owned laptop is used and remote access is granted to clinic EMR or option 2: the clinic purchases this equipment using their IT provider and the ESPCN reimburses; the ESPCN must pre-approve the cost, and requires documentation of proof of purchase, payment and receipt of item)
- Incremental EMR license costs for initial set up (ongoing subscription fees are not covered)
- Blood pressure machine for Primary Care Nurse use (one BP averaging professional machine for the office and two loaner BP machines for patient use)
- Office furniture - desk, chair, locking cabinet

Physicians and clinics are responsible for the ongoing costs of consumable supplies as required for MDT providers. The MDTOH payment is intended to support coverage of these costs. If a clinic has elected to forego MDTOH, they are still required to cover the costs of consumable supplies. The following are examples of ongoing consumable costs:

- Office supplies (e.g., paper, pens, etc.)
- Medical/clinic supplies (e.g., speculums, needles, wound care supplies, etc.) required for patient care
- Access to the clinic printer and associated costs (paper, toner, ink)
- Monthly EMR subscription costs

Invoicing & Payment

- Clinics are provided with an email of that months' MDTOH amount (reviewed by the Primary Care Manager for accuracy), the clinic must then invoice the ESPCN monthly for payment.
- The MDTOH is considered a taxable supply. GST should be applied if the clinic has registered for a GST number and is not considered a small supplier. Use the CRA tool[14] to determine if you qualify.
- Invoices that are submitted late may not be eligible for payment. A clinic will be given one written warning. Subsequent to the warning, invoices submitted more than three months in arrears will not be paid.

[14] https://www.canada.ca/en/revenue-agency/services/tax/businesses/topics/gst-hst-businesses/when-register-charge.html

- Panel numbers are released semi-annually and are updated in April and in October. FTE and MDTOH are re-examined at that time.
- Invoices can be emailed to accountspayable@espcn.ca.
- Invoices should contain Payee contact information, the clinic's GST number if applicable, the date and the period the invoice covers, along with the amount.

Asset Management

The ESPCN will provide office equipment, within reason, to support the co-location of MDT. This may include items such as a desk, bookshelf, or locking cabinet if the clinic does not have anything currently suitable.

Clinics will work with their Primary Care Manager to determine what is needed and all items must be approved before they are purchased. Once approved, the clinic can purchase the appropriate equipment and submit the receipts to the Primary Care Manager for reimbursement.

If the ESPCN supplies an item to the clinic (e.g. HUTV), the PCN is the owner of the asset and the clinic must return the items if their membership is ever canceled.

Requirement & Expectations for in-clinic supports

Requirements

- Dedicated office and/or exam room space is required for the team to conduct one-on-one patient visits.
- EMR access with unique log in (including remote EMR access).
- Equipment: computer, printer, and telephone access (the ESPCN can provide assistance with initial set up).
- MOA / administrative support, as required, for multidisciplinary practice, including support for scheduling, referral management, faxing, reminder calls, etc.
- Netcare access is required for all MDT and PMAs at every different clinic they practice in.
- Orientation to the clinic policies and procedure, including EMR training.

See MDT Overhead (MDTOH) for information and details on how your MDTOH payments support you in providing the above requirements for MDT ESPCN staff. If a clinic elects to forego MDTOH, they must still meet the same requirements.

Expectations

- Physicians/clinics are required to give two weeks' notice to the ESPCN when a physician is away or clinics are closed for any period of time.

- ESPCN employees cannot see patients in clinic without at least one other clinic employee present. Performance of some patient visit activities require physician presence as specified in the Medical Directives. ESPCN employees may be in clinic alone when no patients are present.
- Physicians are expected to display professional, collaborative behaviour when working with ESPCN employees, and must be willing to meet with ESPCN leadership to discuss ongoing collaborative working relationships when concerns arise from any parties.

Clinic Safety

The ESPCN Health and Safety Committee has developed a clinic safety toolkit for our member clinics as a resource for community physicians and teams. This toolkit provides clinics with tools to help prepare for, prevent, and respond to violent incidents.

The ESPCN's Clinic Safety Checklist (Appendix K) includes orientation details such as review of emergency exit location(s), emergency equipment (such as first aid kits, AEDs and oxygen), fire extinguishers, muster point location(s), and the emergency response plan and contacts. This should also include orientation to all policies and procedures related to safety, harassment and violence prevention.

Safety considerations:

- In clinic safety plan review, including the clinic safety checklist and clinic tour
- Infection control as per CPSA standards[15]
- The ESPCN provides personal protective equipment (PPE) for our staff

Medical Directives

A Medical Directive is an order for a procedure, treatment, drug, or intervention that may be implemented for a number of patients when specific conditions are met and specific circumstances exist.

Medical Directives, policies, and protocols established by the ESPCN provide support for performance of restricted activities by identifying parameters and limitations, outlining educational requirements for performing restricted activity interventions, and promoting quality assurance and evaluation.

Medical Directives allow nurses to work within established protocols to perform skills (e.g., immunizations, wart treatment, paps, etc.) without direct physician supervision, and if

[15] https://cpsa.ca/facilities-clinics/ipac/

authorized by the physician, without a need for a written order for each patient at every occurrence.

Each directive is formally reviewed and endorsed by the Clinical Governance Committee, and undergoes review and revision as needed.

ESPCN PATIENT PROGRAMS AND SUPPORTS

Central Office Services

Though the ESPCN operates in a primarily decentralized model, there are some centralized services available to all patients and centralized services available to patients who do not have a specific type of provider co-located in their clinic. The central office is open from 8:00 a.m. to 5:00 p.m. Monday to Thursday and from 8:00 a.m. to 4:00 p.m. on Fridays

Central MDT

Member physicians that do not have co-located MDT in their clinic can refer to the central MDT that consists of RN, BHC, SW, RD, ES, RT, and Psychiatrist using the ESPCN referral form in Appendix E.

Lower Leg Assessment Clinic

The Lower Leg Assessment Clinic (LLAC) is a RN and OT run clinic that accepts referrals for patients requiring comprehensive lower leg assessments, edema management, compression therapy treatment, and wound consults. The LLAC team can authorize Alberta Aids to Daily Living (AADL) funding for compression stockings, and therapeutic footwear to individuals who suffer from neuropathy.

Seniors' Centre Without Walls

Seniors' Centre Without Walls[16] (SCWW) is a telephone-based program that isolated seniors 55+ can call into for interactive games, education sessions, exercise, conversation and friendship. Request resources or learn more by emailing SCWW@espcn.ca.

Translation Services

LanguageLine[17] is a professional medical interpretation company contracted by AHS to access language interpretation services over the phone or video. Interpretation is provided in 240 languages, and is available on-demand, 24/7 with no need for an appointment. You can

[16] https://www.edmontonsouthsidepcn.ca/scww/
[17] https://www.languageline.com/s/

also access a video interpreter on Zoom for American Sign Language. Language Line instructions and access codes can be found in Appendix L, or by connecting with your Primary Care Manager.

Another resource to consider is Multicultural Health Brokers (MCHB)[18]. MCHB aims to bridge the gap between newcomer families and Canadian society, serves 23 cultural/language communities, and has various programs from perinatal health, youth initiatives and seniors outreach and offers holistic support. They connect families with health programs with a culturally and linguistically relevant approach.

Patient Group Programs and Workshops

The ESPCN offers a number of patient workshops covering health topics such as nutrition, pregnancy, exercise, lung health, mental health, healthy aging and more. Most workshops are open to patients to self-refer, but a few require referral from a physician or ESPCN staff. See the central referral form in Appendix E for more details.

A full list of available workshops can be found on the ESPCN website[19] or the workshop tear-away pads for your office. If you require workshop resources, please contact your Primary Care Manager.

[18] https://mchb.org/
[19] https://www.edmontonsouthsidepcn.ca/workshops/

NUTRITION

Weight Management / $5
Learn about what affects our weight and how to identify and overcome barriers you're facing. Work with a Registered Dietitian to set goals and make real changes in your life.

Label Reading / No cost
Learn to read food labels with the help of a Registered Dietitian. Feel confident in understanding labels, comparing food, and picking healthier options at the store.

Grocery Shopping Tours / No cost
Grocery shopping can be overwhelming but with the help of a Registered Dietitian, you can learn to navigate the aisles and make healthy food choices. Practice your skills from our Label Reading workshop and gain the confidence to make the best choices for you and your family.

Meal Planning / No cost
Meal planning can help you save time and money and help you eat healthier. Join a Registered Dietitian to learn the steps to successfully plan a week's worth of meals.

MENTAL HEALTH

Relaxation / $5
Practicing relaxation techniques will help you manage stress and anxiety in your life. Learn effective techniques like deep breathing, mindfulness and muscle relaxation.

Happiness Basics / $5
Increase your happiness by learning and practicing ways to improve your mood, vitality and energy. Develop the tools to add more joy to your everyday life.

Emotional Regulation / $5
For those who have difficulty controlling their emotions and feels that their behaviour is causing chaos in their life. Learn and practice mindfulness skills to cope with emotionally stressful situations.

Changeways™ / $5
Learn practical strategies that will help manage symptoms of depression and anxiety through goal setting, challenging negative thinking habits and addressing lifestyle factors. You must attend an information session before starting this program.

Changeways™ for the Older Adult / $5
For adults 60+ who want to learn strategies for overcoming stress, anxiety and depression. Explore the changes that come with life experience including retirement, healthy aging and being a parent of adult children.

Parent and Child Anxiety Group / $5
Together, guardians and children (ages 6-12) will learn to recognize the signs of unwanted thoughts and feelings and develop the tools to manage anxiety. Guardians must attend every class.

Teen Anxiety Group / $5
Teens aged 13-17 will learn helpful tools to manage anxiety. This group is great for any teen that feels overwhelmed by stress, irrational fears or school stresses. Guardians must attend the first class.

HEALTHY AGING

Moving for Memory / $5 – Referral needed
Focused on memory improvement, this group uses physical activity, brain games and education to teach participants how to boost their ability to remember.

Personal Directives/ Enduring Power of Attorney / No cost
Planning for your future is one of the best investments you can make – for you and your family. Anyone 18+ years of age will be guided through the steps to complete these legal documents to appoint a person(s) to trust with your financial, personal, and health related decisions if ever you are unable to do so for yourself.

Seniors' Centre Without Walls / No cost
A seniors' centre from the comfort of your own home! A free phone-based seniors program that provides an opportunity for older adults 55+ to enjoy interactive information sessions, educational programs, games and friendly conversation. Provides opportunities to socialize, learn new skills and stay connected.

LUNG HEALTH

Breathing For Health / $20 – Referral needed
This Pulmonary Rehabilitation program is designed for those living with chronic lung conditions and feeling well enough to join an in-person class. Each session provides an hour of education and an hour of supervised exercise to help individuals improve their breathing management, physical activity and overall quality of life.

COPD Wellness / No cost
If you are facing challenges attending an in-person pulmonary rehabilitation program and are living with a chronic lung condition, this phone-based program is for you. Learn breathing techniques, managing energy and respiratory infections, environmental and mood factors, and so much more.

QuitCore / No cost
This support program provides the tools and strategies to quit using tobacco and connects you with others on the same journey. Develop a quit plan that works for you, learn ways to deal with withdrawal and cravings, and get tips on healthy eating, physical activity, ways to manage stress and prevent restarting.

EXERCISE

Moving for Health / $20
Become more confident and knowledgeable with physical activity. Join a supervised exercise group to learn how to build your healthy lifestyle through movement.

Transition to Community Recreation Centre / No cost
Meet your Exercise Specialist at one of our participating recreation centres to get better acquainted with working out at a gym. Learn about equipment and get more comfortable navigating a gym during this class.

GLA:D™ / $20 – Referral needed
Focused on the treatment and management of osteoarthritis with physical activity, this evidence-based group will help you build strength, manage your symptoms, improve your range of motion, and help you take control of your condition.

Walking Group / No cost
Join an Exercise Specialist for a year round 45 to 60 minute walk around the ESPCN office's neighbourhood. Be sure to bring good walking shoes, water and weather appropriate clothing.

PREGNANCY

Early Prenatal Group / $5
Provides education for expecting parents who are in the first 20 weeks of their pregnancy. Topics include prenatal care, management of common symptoms, nutrition and physical activity. Partners or a support person are encouraged to join.

Group Prenatal Class / $5
Join health professionals who specialize in pregnancy, birth and newborn care to discuss topics such as physical activity, self-care and mental health, comfort measures during labour and birth, infant care, breastfeeding and parenting. For expecting parents over 20 weeks. Partners or a support person are encouraged to join.

B.E.S.T. Breastfeeding Café / $2 Drop in fee
A weekly community support group for breastfeeding mothers. Meet with lactation trained nurses to ask questions about latch, positioning, and newborn behaviour while gaining support from other breastfeeding mothers. A new topic is explored each week such as coping and mental health, nutrition for breastfeeding mothers, physical activity in the postpartum period, and community resources.

Primary Care Network
EDMONTON SOUTHSIDE

Call to register
780.395.2626
Learn more at
EdmontonSouthsidePCN.ca
3110 Calgary Trail NW
Edmonton, AB T6J 6V4

Innovation in the ESPCN and Practices

Optimizing the Medical Home

The ESPCN enhances the delivery of primary care by contributing to the Patient's Medical Home and fostering the community resources that contribute to individual well-being. Becoming a PMH means the family physician and team commit to changing the way the care is delivered in pursuit of continual improvement supported by appropriate funding and infrastructure. The Patient's Medical Home (PMH) is integral to Alberta's primary health care transformation strategy. The ESPCN enhances the delivery of primary care by contributing to the Patient's Medical Home and fostering the community resources that contribute to individual well-being.

Quality Improvement

In 2017, Quality Improvement (QI) was formalized in the ESPCN business plan to place priority on the development of the patient-centred medical homes and to support the growth of this culture within clinics. Each ESPCN member clinic has varying degrees of PMH readiness, existing QI practices, and readiness for change. The ESPCN responds to this diversity by applying common principles while supporting QI-specific activities that are important and relevant to member physicians and their teams.

The ESPCN offers different opportunities to engage family physicians and their teams in quality improvement activities that support PMH transformation including in-clinic supports from the QI team, as well as team-based workshops.

Medical home optimization topics include:

- Improving patient access to services
- Identifying and managing your panel
- Supporting preventative health screening
- Optimizing team-based care
- Proactive management of defined populations within a panel
- Supporting continuity and information flow (CII/CPAR)

The PMA role within a clinic is foundational to supporting a clinic's journey towards being a Patient's Medical Home.

Supporting Continuity and Information Flow: CII/CPAR

CII/CPAR stands for Community Information Integration (CII) and Central Patient Attachment Registry (CPAR). CII is a provincial mechanism to integrate community EMRs with two-way data flow through Alberta Netcare. CPAR is a provincial system that captures the confirmed relationship of a primary provider and their paneled patients. These systems were

developed at the request of family physicians in Alberta to support continuity and information flow. AH has set a target that 80% of physicians in PCNs will adopt CII/CPAR by May 2023.

CII/CPAR

- Enables the sharing of important healthcare information between a patient's family physician and other providers in a patient's circle of care.
- Facilitates the sharing of community encounter digest reports to other providers.
- Confirms the relationship between a patient and their primary provider in Alberta Netcare.
- Allows family physicians to identify and coordinate when patients are on multiple panels.
- Delivers key acute care information to primary providers when their patient has a hospitalization, day surgery or ER visit at any AHS facility in the province
- CPAR-participating family physicians and pediatricians' name will display in Alberta Netcare in the demographic area of patient's record.

QI Annual Plan

The ESPCN 2021-2024 business plan includes supports for clinics to develop quality improvement plans. Your PCN quality improvement team can support you to develop an annual improvement plan and provide practical implementation support to help you meet your goals. Quality improvement plans are becoming more and more common across the PCNs, the zones, and the province. In addition, CPSA's Physician Practice Improvement Program[20] will also require practices to incorporate practice improvement activities in the near future.

Evaluation

The ESPCN supports a culture of learning and improvement by using program evaluation, measurement, and performance monitoring strategies. The evaluation team helps with program evaluation, measurement, and performance monitoring.

Program Evaluation

New programs and services are evaluated to support ESPCN leadership decision-making, to ensure our services are meeting their intended impacts, and to drive improvements. Clinical team members are instrumental in setting the direction of program evaluations including the framework design, interpretation of results, and generating recommendations.

[20] https://cpsa.ca/physicians-competence/ppip/

Measurement

The ESPCN supports clinics working on Medical Home Optimization goals to collect clinic-level data, when appropriate, to inform a clinic's improvement projects.

Performance Monitoring

The ESPCN business plan includes a comprehensive evaluation framework for each priority initiative. Each PCN in Alberta is required to report their progress to AH in annual reporting.

The PCN Grant Agreement also includes performance metrics for all PCNS, collectively referred to as Schedule B indicators. PCN annual reporting must include results of each Schedule B indicator. Individual physician or clinic data is never included in Schedule B reporting- data is summarized in aggregate, anonymized form. The list of Schedule B performance indicators for Alberta PCNs is listed in Appendix G.

PRIVACY & HEALTH INFORMATION

Health Information Act (HIA)

Physicians are deemed **custodians** of health information under the Health Information Act[21] (HIA). The HIA places a number of duties as the responsibility of the custodian.

As custodians, member physicians are responsible for all elements of their Clinic Privacy and Security Program[22], including how ESPCN-employed staff uses, collects, and discloses health information in the member's clinic.

When ESPCN-employed clinical staff (Registered Nurses, Registered Dietitians, Behavioural Health Consultants, Respiratory Therapists, Exercise Specialists, Social Workers) and administrative or Quality Improvement staff (Improvement Facilitators, Panel Management Assistants, EMR Consultants) work within member physician clinics, they will act as **affiliates** of the custodian/physicians. This allows ESPCN-employed staff to access patient care records and document care provided in the clinic EMR or paper chart as part of the care team. This also means that the custodian/physicians are responsible for the actions of their affiliates. For this reason, we encourage physicians/clinics to provide guidance and training to ESPCN-employed staff on clinic-specific privacy and security policies and procedures.

[21] https://www.qp.alberta.ca/1266.cfm?page=H05.cfm&leg_type=Acts
[22] https://www.albertadoctors.org/leaders-partners/clinic-patient-privacy/privacy-compliance-and-breaches

Because ESPCN-employed staff function as affiliates of the custodian/physicians, the clinic must request Alberta Netcare access for MDT providers accessing Alberta Netcare for patients at each specific clinic.

In the unfortunate event of a health information privacy breach within a physician clinic, if the information was under care of the custodian (physician), they will be responsible for appropriate breach management and reporting requirements under the HIA. The ESPCN Privacy Officer is available to support the physician and clinic in this process through offering guidance and strategizing ways to mitigate risk and prevent future breaches. Contact the ESPCN Privacy Officer at Privacy@espcn.ca.

The HIA provides basic requirements for the sharing and management of health information. There are two types of agreements that apply to physicians related to their ESPCN membership: Information Manager Agreement and Information Sharing Agreement.

Information Manager Agreement (IMA)

Membership in the ESPCN requires that member physicians, who are the custodians of Health Information, permit the ESPCN access to identifiable patient information to allow "proper monitoring, information sharing, accountability and evaluation" (Letter of Participation). This relationship places the ESPCN into the role of an Information Manager under the HIA.

An IMA defines this relationship between the custodian of health information (physician) and the information manager (ESPCN) such that the custodian may provide health information to the information manager without the consent of the individuals who are subjects of the information for the purposes authorized in the agreement.

Examples of data collected and shared between member physicians and the ESPCN:

- Encounter data detailing MDT provider activities with patients in member clinics
- Transitions of Care admission and discharge information obtained from Alberta Netcare

Information Sharing Agreement (ISA)

An ISA applies when custodians are sharing health information in an EMR. The ISA clarifies access, transfer, and return of patient records. An ISA is only applicable between the ESPCN and member physicians when physicians are using the central ESPCN office EMR. The use of ISAs is not specifically addressed in the HIA, however, they are encouraged in CPSA's Standards of Practice Regarding Patient Record Retention[23].

[23] https://cpsa.ca/physicians/standards-of-practice/patient-record-retention

In the case of a health information privacy breach that occurs when the ESPCN is in possession of and responsible for security of the health information (information from the ESPCN EMR or identifiable information that had previously been collected from physicians, i.e. encounter data once received by the ESPCN), the ESPCN will be responsible for breach management and reporting according to the HIA.

Privacy Impact Assessment (PIA)

A PIA is a process of analysis that helps to identify and address potential privacy risks related to the collection, use, and disclosure of individually identifying personal or health information (OIPC). Section 64 of the HIA requires that custodians submit a PIA for review by the OIPC. As such, members of the ESPCN are required to have an active PIA. PIA numbers from member physicians and clinics are provided to AH as a condition of membership.

- For more information about the requirements of a PIA, please see https://www.oipc.ab.ca/action-items/privacy-impact-assessments.aspx
- The AMA offers support related to navigating privacy requirements and tools. Please contact PrivacySPaDs@albertadoctors.org
- There are a number of privacy consultants operating in Alberta that can also support PIA development. Please reach out to the ESPCN Privacy Officer if you would like assistance finding an appropriate consultant for your practice.

ESPCN Lead Custodian Role

- Functions as the custodian of all health information and records at the ESPCN central office, which are primarily contained within the ESPCN EMR.
- Functions as the custodian for Netcare access when ESPCN staff are providing patient care at the central office.
- Responsible for agreements in place with other custodians who access and share health information with the ESPCN (i.e., information sharing agreement).
- The Clinical Director is the ESPCN Lead Custodian.

ESPCN Privacy Officer Role

- Oversees the ESPCN central clinic privacy and security and ensures compliance with the HIA.
- Responds to third party requests for patient health information contained in the ESPCN central EMR.
- Supports member physicians and clinics related to privacy matters as required related to integration of ESPCN staff, QI projects, breach management, or other questions and concerns.

- The Primary Care Manager that oversees the Central ESPCN office is the Privacy Officer
- Any privacy questions related to ESPCN can be directed to Privacy@espcn.ca

MEMBERSHIP BENEFITS

UpToDate

UpToDate[24] is an evidence-based resource medical professionals trust to find clinical answers quickly and easily. There are more than 12,000 topics in 25 specialties, continually updated and reviewed by leading experts. Connect to UpToDate through their Mobile App[25] or on any computer. The ESPCN provides this subscription-based service to all physician members and ESPCN staff for free. In order to maintain uninterrupted access to UpToDate, you must re-verify your affiliation with the ESPCN once every 90 days by logging in[26] through the Physician Login on the ESPCN website. Please contact your Primary Care Manager to get access.

Alberta Find a Doctor

Alberta Find a Doctor[27] (AFAD) is a provincial initiative developed by PCNs, the AMA and AHS to help unattached patients find a family doctor. The ESPCN member physicians are listed on the site from the information that is supplied upon membership to the PCN, through our physician database. It is important that members inform the ESPCN Physician Membership Coordinator when they change their "accepting/not accepting new patients" status so that this information can be updated in our database.

Patients use AFAD in two ways, the self-search option or the 'Help Me' option. Edmonton zone PCNs have invested in helping the unattached in a more robust way by employing Patient Attachment Assistants that work with clinics to attach patients and early results have been very positive. If you are interested in learning more about this program, contact PAHelp@espcn.ca for more information.

HUTV

HUTV offers engaging content for your patients sitting in your waiting room with a focus on improving well-being. It gives patients the information they need to actively participate in

[24] https://www.uptodate.com/home/product
[25] https://www.uptodate.com/home/how-access-uptodate
[26] https://www.edmontonsouthsidepcn.ca/wp-login.php
[27] https://albertafindadoctor.ca/

their health decisions. If you are interested in having an HUTV in your waiting room, please contact your Primary Care Manager.

GET INVOLVED & STAY INFORMED

Committees

Physician Advisory Committee (PAC)

The PAC is a forum for ESPCN members to provide perspective to strategic, policy and operational issues of importance to the organization. Participants will gain insight into the political, financial and environmental influences that affect the ESPCN and the committee offers insight, constructive feedback and/or new ideas to matters at hand. If you are interested in joining the PAC, contact Andrea Atkins, Executive Director at Andrea.Atkins@espcn.ca.

Clinical Governance

The ESPCN Clinical Governance Committee reviews all current and new programming requests with a focus on clinical operations. Examples include medical directives, new QI or patient group proposals, infection prevention and control manual, etc. The Committee consists of ESPCN senior management, three physician members, and one staff representative from each discipline. If you are interested in participating, contact Kacey Keyko, Clinical Director at Kacey.Keyko@espcnca.

Research

The ESPCN Research Committee reviews all requests for the ESPCN to participate in research projects and determines the impact and appropriateness of the request. The Committee consists of ESPCN management, multidisciplinary team members, and a member physician representative. If you are interested in participating, contact Jessica Schaub, Evaluation Manager at Jessica.Schaub@espcn.ca.

Annual Events

Annual General Meeting (AGM)

Held in June each year, this is a meeting for the member physicians to review ESPCN business, vote for motions and elect their BOD. As written in the bylaws, there must be a minimum of 25% of members in attendance or who have submitted their proxy forms to hold the AGM in order to reach quorum. Upon joining the PCN, members are informed that attendance at the AGM (or proxy submission) is an essential part of PCN membership.

Town Halls

These events are held throughout the year focusing on a variety of topics that affect physician members.

Communication Tools

Clinical Newsletters

Physician members and clinic staff will receive "Your PCN News" in your inbox monthly on Wednesdays. This online newsletter highlights important primary care news such as ESPCN business, operational and governance updates, patient resources and professional development events. Any clinic staff can subscribe to the newsletter[28].

Physician Locums

For physicians looking to find a locum or to post your availability as a locum, please use the AMA's Physician Locum Services® (PLS) Job Board[29].

ESPCN Website

A new patient focused website was launched in the Fall of 2021. The goal of this redesigned site is to be an easy to use health resource for patients and healthcare professionals serving our patients. Visit www.edmontonsouthsidepcn.ca.

Webinars & Workshops

The ESPCN hosts a number of educational opportunities for members and their teams. Past topics have included CII/CPAR, heart failure, COPD, and opioid dependency. The ESPCN also has partnered with the Physician Learning Program (PLP)[30] to offer sessions throughout the year.

CONTACT LIST

- For clinic questions contact your Primary Care Manager
- For board questions contact Andrea Atkins, Executive Director at Andrea.Atkins@espcn.ca
- For membership questions contact Karoline Kiddine, Physician Membership and Community Development Coordinator at Karoline.Kiddine@espcn.ca

[28] https://edmontonsouthsidepcn.us18.list-manage.com/subscribe?u=800fd35196b5607c4cd0205ee&id=421f510647
[29] https://www.albertadoctors.org/services/physicians/pls/job-board
[30] https://www.albertadoctors.org/leaders-partners/quality-and-education-programs/physician-learning-program

DEFINITIONS

AFAD	Alberta Find a Doctor
AH	Alberta Health
AHPC	Alberta Health Physician Consent form
AHS	Alberta Health Services
BPA	Business Plan Agreement
CQI	Continuous quality improvement
EMR	Electronic Medical Record
FTE	Full-Time Equivalent
HIA	Health Information Act
HUTV	Health Unlimited TV
IF	Improvement Facilitator
LOP	Letter of Participation
MDTOH	Multidisciplinary Team Overhead
NFP	Not-for-profit
NPC	Not-For-Profit Corporation
PCM	Primary Care Manager
PCN	Primary Care Network
PIA	Privacy Impact Assessment
PMH	Patients Medical Home
QI	Quality Improvement
RHA	Regional Health Authority

APPENDICES

Appendix A: Article 7 of the PCI Policy Manual - Enrolment Policies

(https://www.pcnpmo.ca/access/Documents/PCN%20Policy%20Manual.pdf)

7.1 General Enrolment Policy

(a) Initially, all Primary Care Network Enrolments will be informal.
(b) Subject to a tripartite decision to implement Formal Enrolment, patients shall have the option of being formally or informally enrolled.
(c) Primary Care Networks may not discriminate amongst existing Primary Care Network patients with respect to whether they offer formal or informal Enrolment.
(d) Subject to a tripartite decision to implement Formal Enrolment, Primary Care Networks may offer either informal enrolment or formal enrolment to new patients.
(e) Enrolment is with the Primary Care Network, not the individual physician.
(f) Primary Care Networks may compete for patients but they must fairly represent the services they provide to current and prospective patients.
(g) Core providers can initiate and maintain enrolments by providing services. Core providers are family physicians /general practitioners and other health care providers as approved by PCIC. Core providers may also be registered at another PCN as an Associate Provider. Further policy related to Associate Providers is under development.
(h) There will be one Enrolment list for a Primary Care Network. Practices, providers and facilities will use the same Primary Care Network Enrolment list.
(i) There will be two "payment details" lists for each Primary Care Network. 1) An aggregated list of enrollees by age and sex and 2) a detailed patient list for each provider by individual clinic (access to the latter will be managed in accordance with HIA requirements).
(j) Access to the Primary Care Network Enrolment lists and operational reporting information will be through an established access process, for custodians and their affiliates as requested by a Primary Care Network.

7.2 Informal Enrolment Policy

(a) The first group of Primary Care Networks will initially operate under informal Enrolment, which is the default method of enrolling patients in a Primary Care Network. Informal Enrolment is based on patient encounters with a Primary Care Network health care provider, in a Primary Care Network service delivery location, for services included in the list of Primary Care Network service responsibilities (Article 8 of the PCI Agreement).
(b) A patient is "automatically" informally enrolled with a Primary Care Network when s/he has had one or more Encounters over the previous three year period and has been assigned to a Patient panel in accordance with the four cut funding methodology:

(i) Patients whose Encounters are with a single provider are assigned to the Patient panel of that provider;
(ii) Patients not assigned to a panel after step (a) are assigned to the Patient panel of the provider with whom they have had the most Encounters;
(iii) Patients still not assigned to a panel after steps (a) and (b) are assigned to the Patient panel of the provider who completed the last physical exam on that Patient; and
(iv) Remaining Patients are assigned to the Patient panel of the provider with the last recorded Encounter for that Patient;

(c) Informal Enrolment lists are determined by AHW through historical patient utilization.
(d) Informal Enrolment lists are updated semi-annually by AHW.

7.3 Formal Enrolment Policy

(a) Formal Enrolment includes an acknowledgement by the patient and the physician of an ongoing relationship which includes:
(i) The patient's commitment to seek primary care services from the physician and the Primary Care Network.
(ii) The physicians'/core providers' and the Primary Care Network's commitment to provide primary care services to the patient.
(b) Formal Enrolment includes a document signed by both parties that incorporates the above commitments (described as an Enrolment Agreement in Article 9.5 of the PCI Agreement).
(c) Formal Enrolment will become an option for all Primary Care Networks once PCIC is confident that all Primary Care Networks have a fair opportunity to use this approach.
(d) Once formal Enrolment is approved by PCIC, an active Primary Care Network may change its Enrolment from informal to formal or vice versa through an established process as defined by the PCIC.
(e) Patients should be fully informed of the services and programs provided by the Primary Care Network so they can make an informed choice and understand the mutual obligations associated with formal Enrolment.
(f) Subject to a tripartite decision to implement formal enrolment, Primary Care Networks should establish a formal mechanism and a communication package to ensure a consistent approach to the formal enrolment process. This could include designating specific staff, who are familiar with the enrolment process and procedures, to support physicians to enroll patients.
(g) Patients may terminate their formal Enrolment.
(h) Primary Care Networks may terminate the formal Enrolment of a patient if the physician/patient relationship has been terminated in accordance with CPSA guidelines.

Appendix B: Article 11 of the PCI Policy Manual - Per Capita Funding

(https://www.pcnpmo.ca/access/Documents/PCN%20Policy%20Manual.pdf)

11.1 General Per-Capita Funding Policy

(a) The primary objective of the up to $62 per patient annual payment is to substantially improve the provision of primary care to all Albertans, as described in Article 3, section 3.1(e) of the PCI Agreement.
(b) The $62 per patient payment may be used to fulfill the PCI objectives by:
    - Adding value through the provision of new services and or service enhancements including support for other providers (i.e., provide incentives to expand the comprehensiveness of an existing service or fill service gaps)
    - Paying for physician services for which there is currently no remuneration (fee-for-service or other programs) from the Physician Services Budget (PSB) or RHA
(c) PCI monies will not fund existing services provided currently by RHAs, PSB or other initiatives like POSP (i.e., PCI monies are not intended to replace existing funding).
(d) PCI monies may not be used for major infrastructure development including facility construction, etc.
(e) PCI monies may not be used to support or operate physician office systems for individual physicians or physician clinics if there are situations where physicians:
    - Are eligible for Physician Office System Program (POSP) funding but have not yet received it, or
    - Have come to the end of their allocated POSP funding.
(f) PCI monies may be used to operate systems for which the overall Primary Care Network is responsible (e.g., a system for an after-hours clinic).
(g) At the local level, each Primary Care Network will determine how PCI monies will be allocated based on the application of approved principles and the approved business plan.
(h) The retrospective review period will be three years. This will be monitored to ensure it is appropriate. Once Primary Care Networks are operational, AHW will monitor and trend the data to gather more evidence and understanding about patient utilization and provide this information, along with recommendations, for consideration by the PCIC.

Appendix C: Article 3 of the PCI Policy Manual - PCIC Principles for PCN Development

(https://www.pcnpmo.ca/access/Documents/PCN%20Policy%20Manual.pdf)

(a) All parties to the Master Agreement will enable the effective implementation of the Primary Care Initiative by establishing supporting policies and removing policy and regulatory barriers, where practical.
(b) Every resident of Alberta will be eligible to receive primary care services from a Primary Care Network, contingent on development and availability.
(c) Albertans will still have the freedom to choose their physicians.
(d) Physicians will remain free to choose their method of remuneration for insured services (i.e., fee-for-service, alternate relationship plan, etc.).
(e) Participation by physicians in a Primary Care Network is voluntary.
(f) Primary Care Networks will define the respective roles and responsibilities of each party.
(g) A physician group may appeal to the PCIC if a regional health authority (RHA) unreasonably and/or arbitrarily rejects a proposal to establish a Primary Care Network.
(h) Primary Care Networks will be defined by a number of criteria including geographic parameters, natural referral patterns and existing patient populations.
(i) Primary Care Networks will provide primary care services to formally and informally enrolled patients and a reasonable and equitable allocation of unattached patients (unattached patients may be referred to a Primary Care Network based on the patient's residence or work location). Primary Care Networks will not be expected to provide services to a disproportionate number of unattached patients.
(j) Primary Care Networks will be of sufficient size to effectively fulfill the service responsibilities specified in Article 8 of the PCI Agreement and as further defined by the PCIC.
(k) RHAs and physician groups will have the flexibility to develop a Primary Care Network that meets their region's unique needs, within provincially established standards and guidelines.
(l) Primary Care Networks will ensure that the size of their enrolled population is aligned to their service delivery capacity.
(m) Primary Care Networks may have an unlimited number of fee-for-service, alternate relationship plan and RHA physicians, other health care providers and service delivery locations. However, a Primary Care Network cannot be owned by another Primary Care Network or any other corporate entity.
(n) All Primary Care Networks will have the same service responsibilities. These may be changed from time to time by the PCIC. However, existing Primary Care Networks will not be required to deliver newly added services until the Primary Care Network's renewal date, and until the global service responsibility list is updated.

(o) Primary Care Network performance measures and evaluative processes will be developed by the PCIC in collaboration with the physicians and RHAs that are developing and implementing Primary Care Networks.

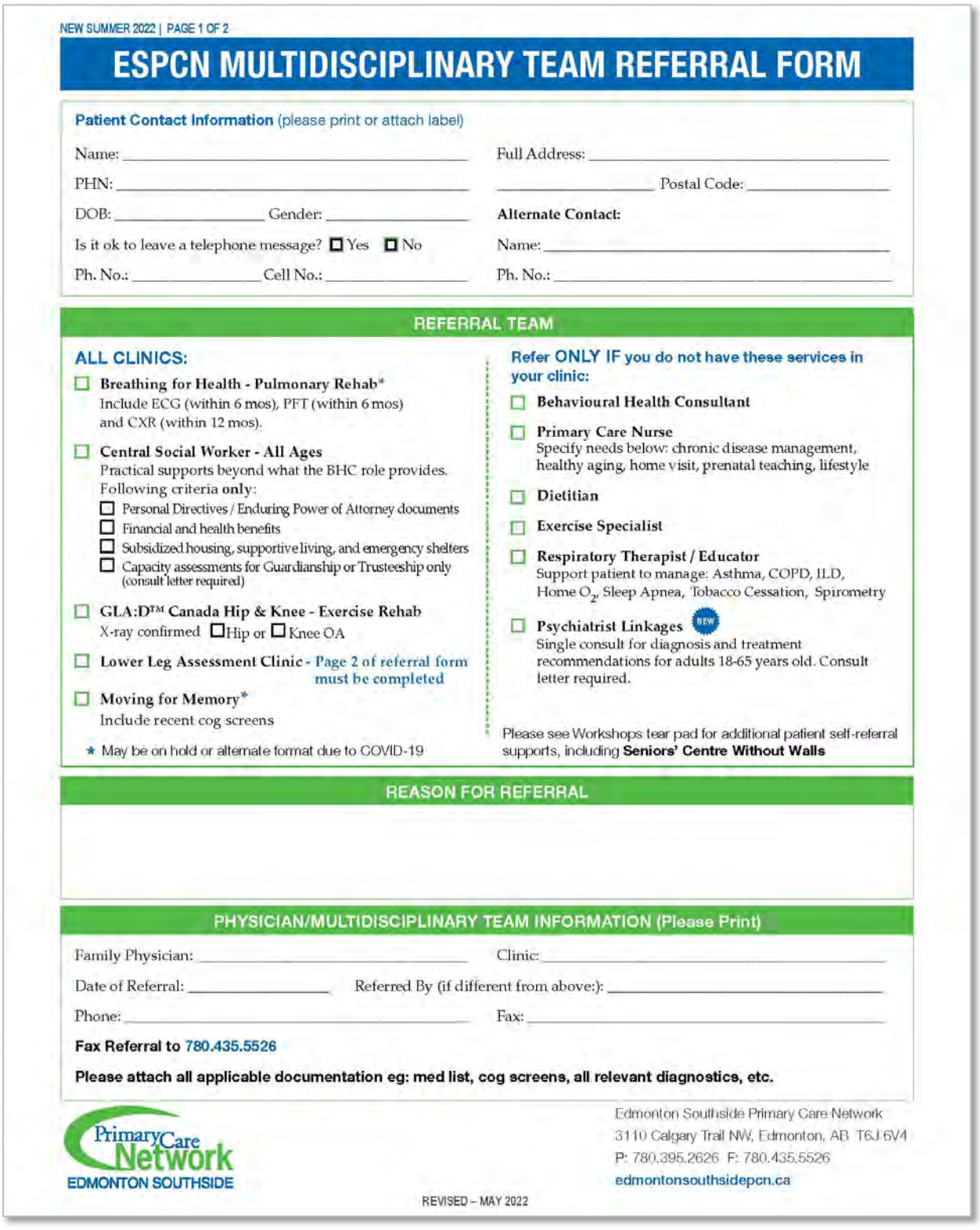
Appendix D: Provincial PCN Policy Information

PCNs are governed by the following policy document created by Alberta Health. Revised in March, 2018.

- (03/07/2018) Primary Care Initiative Policy Manual Version 11, June 17, 2008 - Updated March 2018
- (04/2018) Operational Stability Fund Policy - Frequently Asked Questions
- (04/2016) Community Member Compensation/Reimbursement Policy - Frequently Asked Questions
- (04/2016) Grants, Donations and Gifts Policy - Frequently Asked Questions
- (12/2016) PCN Closure Policy - Frequently Asked Questions

Appendix E: Central Referral Form

https://www.edmontonsouthsidepcn.ca/app/uploads/APPENDIX-E-ESPCN-MDT-Referrals-Summer-2022.pdf



NEW SUMMER 2022 | PAGE 1 OF 2

ESPCN MULTIDISCIPLINARY TEAM REFERRAL FORM

Patient Contact Information (please print or attach label)

Name: _____ Full Address: _____

PHN: _____ _____ Postal Code: _____

DOB: _____ Gender: _____ **Alternate Contact:**

Is it ok to leave a telephone message? ☐ Yes ☐ No Name: _____

Ph. No.: _____ Cell No.: _____ Ph. No.: _____

REFERRAL TEAM

ALL CLINICS:

☐ **Breathing for Health - Pulmonary Rehab***
Include ECG (within 6 mos), PFT (within 6 mos) and CXR (within 12 mos).

☐ **Central Social Worker - All Ages**
Practical supports beyond what the BHC role provides.
Following criteria **only**:
- ☐ Personal Directives / Enduring Power of Attorney documents
- ☐ Financial and health benefits
- ☐ Subsidized housing, supportive living, and emergency shelters
- ☐ Capacity assessments for Guardianship or Trusteeship only (consult letter required)

☐ **GLA:D™ Canada Hip & Knee - Exercise Rehab**
X-ray confirmed ☐ Hip or ☐ Knee OA

☐ **Lower Leg Assessment Clinic** - Page 2 of referral form must be completed

☐ **Moving for Memory***
Include recent cog screens

* May be on hold or alternate format due to COVID-19

Refer ONLY IF you do not have these services in your clinic:

☐ **Behavioural Health Consultant**

☐ **Primary Care Nurse**
Specify needs below: chronic disease management, healthy aging, home visit, prenatal teaching, lifestyle

☐ **Dietitian**

☐ **Exercise Specialist**

☐ **Respiratory Therapist / Educator**
Support patient to manage: Asthma, COPD, ILD, Home O_2, Sleep Apnea, Tobacco Cessation, Spirometry

☐ **Psychiatrist Linkages** NEW
Single consult for diagnosis and treatment recommendations for adults 18-65 years old. Consult letter required.

Please see Workshops tear pad for additional patient self-referral supports, including **Seniors' Centre Without Walls**

REASON FOR REFERRAL

PHYSICIAN/MULTIDISCIPLINARY TEAM INFORMATION (Please Print)

Family Physician: _____ Clinic: _____

Date of Referral: _____ Referred By (if different from above:): _____

Phone: _____ Fax: _____

Fax Referral to 780.435.5526

Please attach all applicable documentation eg: med list, cog screens, all relevant diagnostics, etc.

Primary Care Network
EDMONTON SOUTHSIDE

Edmonton Southside Primary Care Network
3110 Calgary Trail NW, Edmonton, AB T6J 6V4
P: 780.395.2626 F: 780.435.5526
edmontonsouthsidepcn.ca

REVISED – MAY 2022

Appendix F: MDT Full Scope Listing

Registered Nurse Scope

Who is a Registered Nurse?

- A Registered Nurse (or Primary Care Nurse), who works with primary care physicians and the multidisciplinary team to provide comprehensive nursing services and care to patients in primary care.
- Primary Care Nurses provide assessment, screening, healthy lifestyle support, education, self-management support, and chronic disease management across the lifespan with a goal of improving health outcomes and facilitating access to services.
- The role of the Primary Care Nurse involves a comprehensive, holistic, patient centred approach, and the role may vary based on the needs or population we serve.

Services a Primary Care Nurse can provide support for, but not limited to:

Health Promotion/Disease Prevention:

- Prenatal education
- Well child follow up
- Immunizations
- Preventative health education
- Women's health visits including pap test
- Healthy aging including cognitive screening

Chronic Disease Management:

- Diabetes
- Hypertension
- Cardiovascular risk
- Dyslipidemia
- Heart Failure
- Asthma
- COPD
- Basic lifestyle changes (nutrition, exercise)
- Weight management
- Mental Health – depression, anxiety
- Smoking cessation
- Insulin start
- Chronic pain

Care Coordination of Complex Patients:

- Transitions of Care hospital discharge follow up
- Care coordination including with home care and assisting with navigating community resources

Other:

- Injections (medications, allergy immunotherapy, immunizations)
- Ear syringing
- Wart treatments
- Dressing changes
- INR monitoring and warfarin dose adjustments
- Medication review

Nurse Practitioner Scope

Who is a Nurse Practitioner?

A nurse practitioner (NP) is a registered nurse with advanced university education who provides personalized, quality health care to patients. NPs work in partnership with physicians, nurses, and other health care professionals such as social workers, mental health professionals and pharmacists to keep patients, families and communities well.

NPs have additional education and nursing experience, which enables them to:

- Autonomously diagnose and treat illnesses
- Order and interpret tests
- Prescribe medications
- Perform medical procedures

In addition, nurse practitioners are experts in community health care needs assessment and program planning, implementation and evaluation. NPs are also educators and researchers who can be consulted by other health-care team members.

What services can NPs provide?

Nurse practitioners assess, diagnose, treat and monitor a wide range of health problems using an evidence-based approach to their practice. They consult and collaborate with physicians and other health care professionals to meet the needs of the patient population.

NPs provide a wide range of direct care services to people at every stage of life. In addition to treating illnesses, they teach individuals and their families about:

- Healthy living
- Preventing disease
- Managing chronic illness.
- Navigate through the health care system

Engaging patients as full partners in their care plan with attention to self-care to the extent that patients are willing and able to participate is an important aspect of the underlying philosophy of NP care.

Behavioural Health Consultant Scope

Who is the Behavioural Health Consultant?

- An allied health professional, usually a registered social worker or a registered nurse, that works with primary care physicians and the multidisciplinary team to address chronic health and mental health concerns through evidence-based behavioural interventions.
- Any patient whose health is impacted by habits, behaviours, thoughts, and emotions would benefit from a referral to a Behavioural Health Consultant.

Appointment structure:

- Appointments typically last about 25-30 minutes with typically up to 4 follow-up appointments per concern.
- The focus is on skill building, development of coping strategies, and patient self-management of their chronic diseases and mental health through evidence-based behavioural interventions.
- This service is not the same as counselling or therapy.

Services a Behavioural Health Consultant can provide support for, but not limited to:
Mental Health Concerns:

- Stress
- Depression
- Anxiety
- Grief/Bereavement
- Anger
- Relationship Problems
- Financial Strain and Community Navigation

Chronic Health Concerns:

- Hypertension
- Chronic Pain
- Headaches
- Fibromyalgia
- Diabetes
- COPD
- Insomnia/Sleep Disturbance
- Gastrointestinal Problems (GERD, IBS)
- Smoking Cessation
- Obesity Management
- Substance Use
- Sexual Dysfunction

Possible outcomes for patients:

- Development of behavioural strategies to manage mental health and chronic health concerns.
- Patients develop better control over thoughts, behaviours and emotions.
- Patients taking a more active role in their health.
- Patients having a better health care experience within their medical home.

Registered Dietitian Scope

Who is a Registered Dietitian?

A Registered Dietitian (RD) is an allied health professional uniquely trained to advise on food and nutrition for overall health and wellness. RDs are recognized as nutrition experts who are qualified to provide medical nutrition therapy for the prevention, delay and management of disease.

Primary care RDs provide more than "just" nutrition advice. RDs have a wide scope and contribute a broad range of skills to their practice.

- Practitioners: provide nutrition counselling using motivational interviewing, problem solving and cognitive behavioral strategies.

- Educators and researchers: interpret and translate knowledge to patients, communities and other health care providers, write grants for clinical based research and contribute to research reviews
- Leaders: involved in quality improvement plans, design and lead health programs and initiatives

How are RDs educated and regulated?

- Registered Dietitian is a protected title given to professionals that have obtained a bachelor's degree and completed a practicum in Nutrition and Dietetics
- RDs are regulated under the Health Professions Act
- In order to practice, RDs must be registrants of the College of Dietitians of Alberta

What services do RDs provide?

- Provide consultation services to clients of all ages in individual and group settings.
- Facilitate nutrition focused workshops and programs.

Patients can benefit from Dietitian support for the prevention and management of a variety of health conditions including but not limited to the following:

- Eating disorders
- Pregnancy and breastfeeding
- Malnutrition (pediatric FTT, seniors, cancer, malabsorptive disorders)
- CDM (Dyslipidemia, DM, HTN, fatty liver, kidney failure, COPD, Obesity)
- Weight management
- Anemia
- Vegetarian and vegan eating
- Pediatric picky eating
- Allergies and food intolerances
- Digestive disorders (Crohn's, UC, IBS, GERD, celiac)
- Anxiety, depression and other mental health disorders
- Nutrition to support physical activity
- Healthy aging
- Nutrient deficiencies

Exercise Specialist Scope

Who is an Exercise Specialist?

An Exercise Specialist is an allied health professional who promotes and prescribes physical activity to prevent and manage chronic health issues. Exercise Specialists hold at a minimum a bachelor's degree in Physical Education or Kinesiology. They also hold the designation of Certified Exercise Physiologist™ (CEP) through the Canadian Society for Exercise Physiology (CSEP).

Who can Exercise Specialists work with?

Research literature[31] supports the benefits of physical activity for the prevention and management of a variety of health conditions including but not limited to the following conditions:

- Circulatory: hypertension, coronary artery disease, peripheral vascular disease, congestive heart failure.
- Pulmonary: asthma, COPD.
- Musculoskeletal: arthritis/osteoarthritis, fibromyalgia, osteopenia/osteoporosis, sarcopenia, low back pain syndrome.
- Neuromuscular: stroke, multiple sclerosis, spinal cord disability.
- Endocrine & metabolic: dyslipidemia, diabetes, obesity, hypothyroidism.
- Immulogical and Hematological: cancer, chronic fatigue syndrome.
- Mental health: stress, anxiety, depression, attention deficit hyperactivity disorder.
- Special populations: pediatrics, geriatric, bariatric, pre & post natal.

What services can Exercise Specialists provide?

1. Physical Activity Counseling
2. Exercise prescription
3. Supervised exercise training
4. Instruction (for unsupervised exercise training)
5. Education
6. Assessment of physical function

What can an Exercise Specialist NOT do?

Exercise Specialists cannot prescribe physical activity to acutely injured individuals, diagnose pathology based on any assessment performed or administer manual therapies such as massage, electrical modalities, and manipulations.

Respiratory Therapist Scope

Who is a Respiratory Therapist?

Respiratory Therapists (RT) are allied health care professionals who are skilled in assessing and managing people living with a respiratory illness. The role of primary care respiratory therapists is to participate in the planning, implementation, and evaluation of respiratory care plans. RTs are knowledgeable on the current treatment guidelines and medications for chronic lung disease, and offer in-office pre and post bronchodilator spirometry testing.

All RTs working at ESPCN are Certified Respiratory Educators.

[31] Durstine et al. (2009). ACSM's exercise management for persons with chronic diseases and disabilities. Champaign, IL: Human Kinetics & Ehrman et al. (2009). Clinical exercise physiology. Champaign, IL: Human Kinetics.

How are RTs educated and regulated?

- RTs are licensed professionals who have completed a Diploma in Respiratory Therapy
- RTs are regulated under the Health Professions Act
- In order to practice, RTs must be registrants of the College & Association of Respiratory Therapists of AB who mandates a minimum amount of hours worked and a minimum amount of hours devoted to professional development on an annual basis

What services do RTs provide?

- Assessment and management of respiratory symptoms and/or diseases
- Provide patient education on lung health based on current treatment guidelines
- COPD and Asthma Action Plans
- Spirometry Testing
- Smoking cessation
- Facilitate the ESPCN Breathing for Health Pulmonary Rehabilitation Program and virtual COPD Wellness program
- Inhaler education and teaching
- Dyspnea management (breathing techniques to reduce shortness of breath)
- Cough management
- Provide lung health education to PCN MDT and other healthcare providers

Registered Social Worker Scope

Who is a Social Worker?

A Registered Social Worker is an allied health professional who focus on improving health and social well-being by providing practical supports related to the social determinants of health, Social workers engage people and communities to address life challenges and traumatic events, to create change, and build resiliency. At ESPCN the registered social worker is located at the Central office and is referred to as the Central Social Worker, or CSW.

The Central Social Worker (CSW) supports referred patients (Ages 0-62) to identify and access appropriate services, through collaboration with other professionals within the multi-disciplinary team. This position will support referred patients to identify and access appropriate services, through collaboration with other professionals within a multi-disciplinary team.

The Healthy Aging Social Worker (HASW) provides social work services and care to older adults (Ages 63+) including assistance with personal directives, enduring power of attorney documents and capacity assessments for guardianship or trusteeship.

What services do Social Workers provide?

- Psychosocial assessments of referred patients/families
- Assist patients/families to access financial support, housing, employment opportunities and other resources that would improve the patient's quality of life

- They provide assistance with personal directives, enduring power of attorney documents and capacity assessments for guardianship or trusteeship
- Support patients and families to navigate health and social systems, and advocate for them within those systems when required
- Assess, plan, implement and evaluate care and work with patients with complex health care needs

What is the Referral Process?

ESPCN physician and MDT members can refer to either the CSW (for patients aged 0-62) or HASW (for patients aged 63+) on the central referral form.

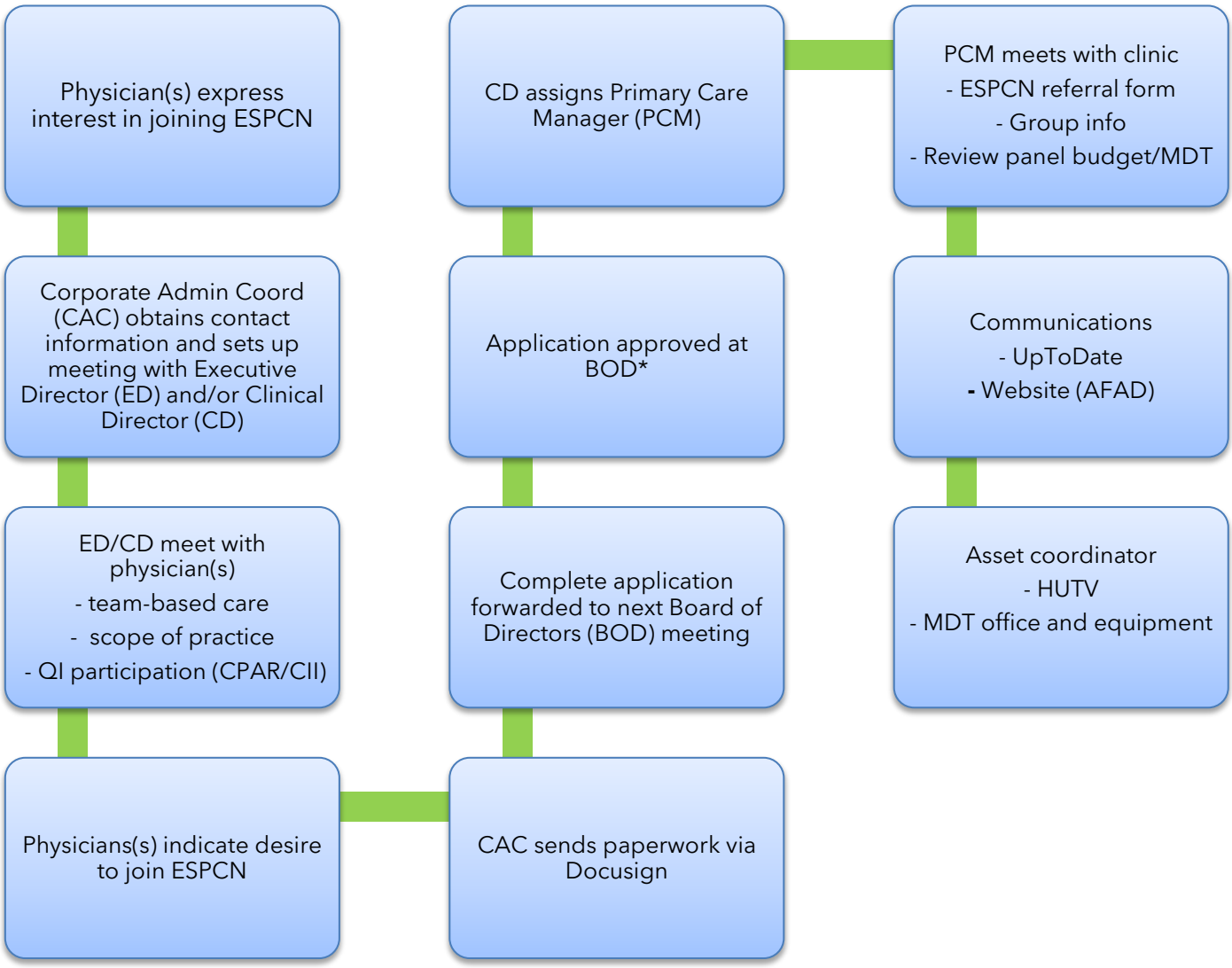
Appendix G: Schedule B - Primary Health Care Indicator Set

The PCN annual report will include results for the performance indicators are outlined below:

Third Next Available Appointment Indicator	Percentage of participating physicians in the PCN who are measuring the Time to Third Next Available Appointment (patient access measure)
Screening Indicator	Compliance with screening as recommended by the Alberta Screening and Prevention Initiative (ASaP)
Patient Experience Indicator	Patient experience of their care during a clinic visit
Team Effectiveness Progress Indicators	Proportion of Participating Physicians/Providers who conducted a team effectiveness survey in the last year
Patient Medical Home Readiness Indicators	As set out in the Business Plan, the PCN is expected to support Participating Physicians/Providers' progress toward Patients' Medical Home Implementation. In order to support Participating Physicians/Providers, the PCN must understand where these Participating Physicians/Providers and the clinics they work in are in PMH implementation including adoption of CII-CPAR a) How many medical clinics do the Participating Physicians/Providers work in? b) How many Participating Physicians/Providers are registered to your PCN? c) How many Participating Physicians/Providers are using a CII-CPAR compatible EMR? d) How many Participating Physicians/Providers have a Privacy Impact Assessment that is up-to-date and reflects the current environment? e) How many Participating Physicians/Providers routinely verify their Panels? f) How many Participating Physicians/Providers routinely verify their Panels by verification method? g) How many Participating Physicians/Providers are routinely submitting verified Panel information to CII-CPAR? h) How many Participating Physicians/Providers are routinely submitting verified Panel information to CII-CPAR and resolving conflicts?

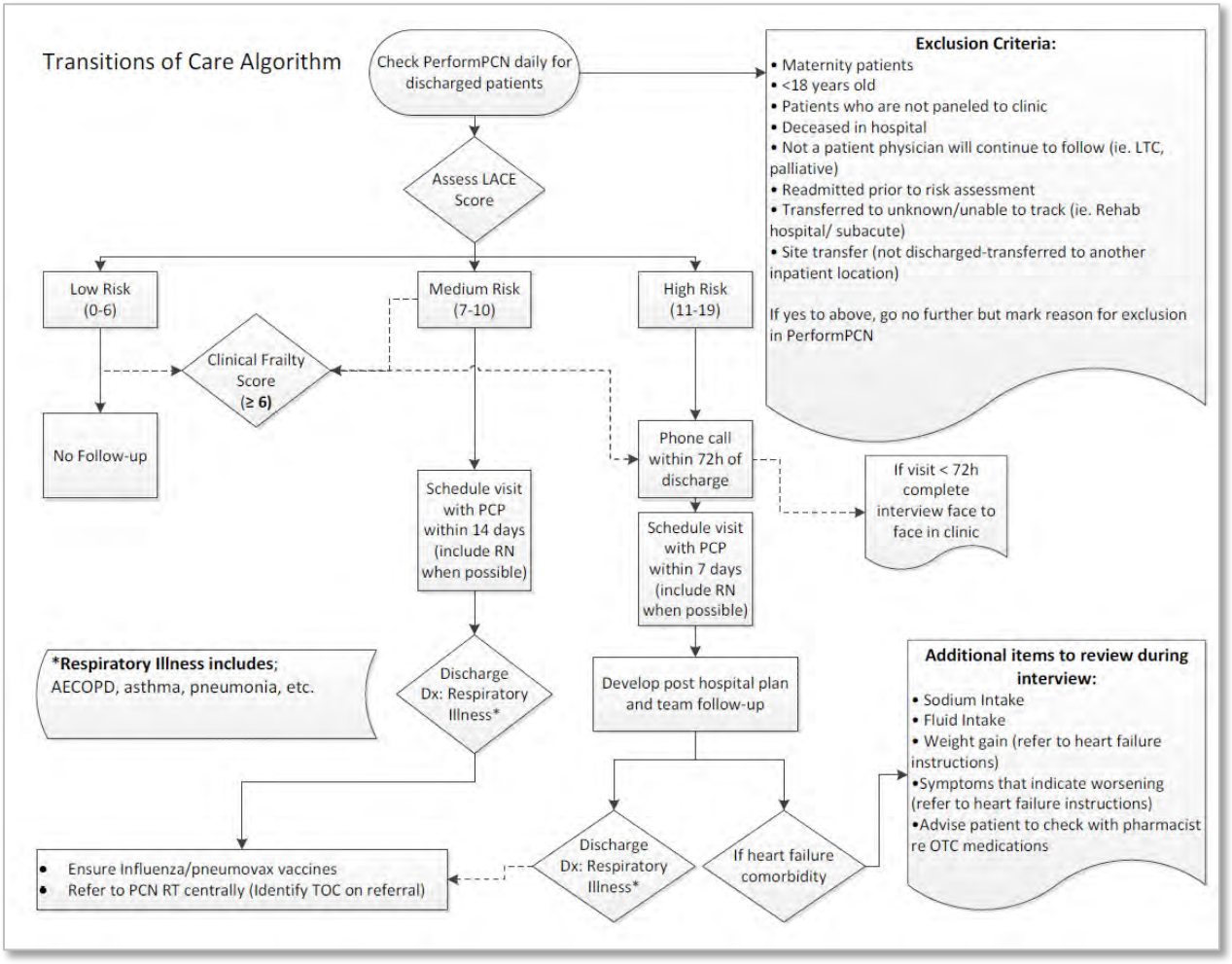
	i) How many Participating Physicians/Providers utilize Panel information for proactive patient management?
Governance Indicator	Completion of PCN governance-related collective self-assessment and performance improvement plan, as required in the PCN program policies
Leadership Indicator	Assessment of the performance of the PCN Administrative Lead and all other staff members directly reporting to the PCN governance body (per the Joint Venture Agreement), as required in the PCN program policies

Appendix H: New Physician Flowchart



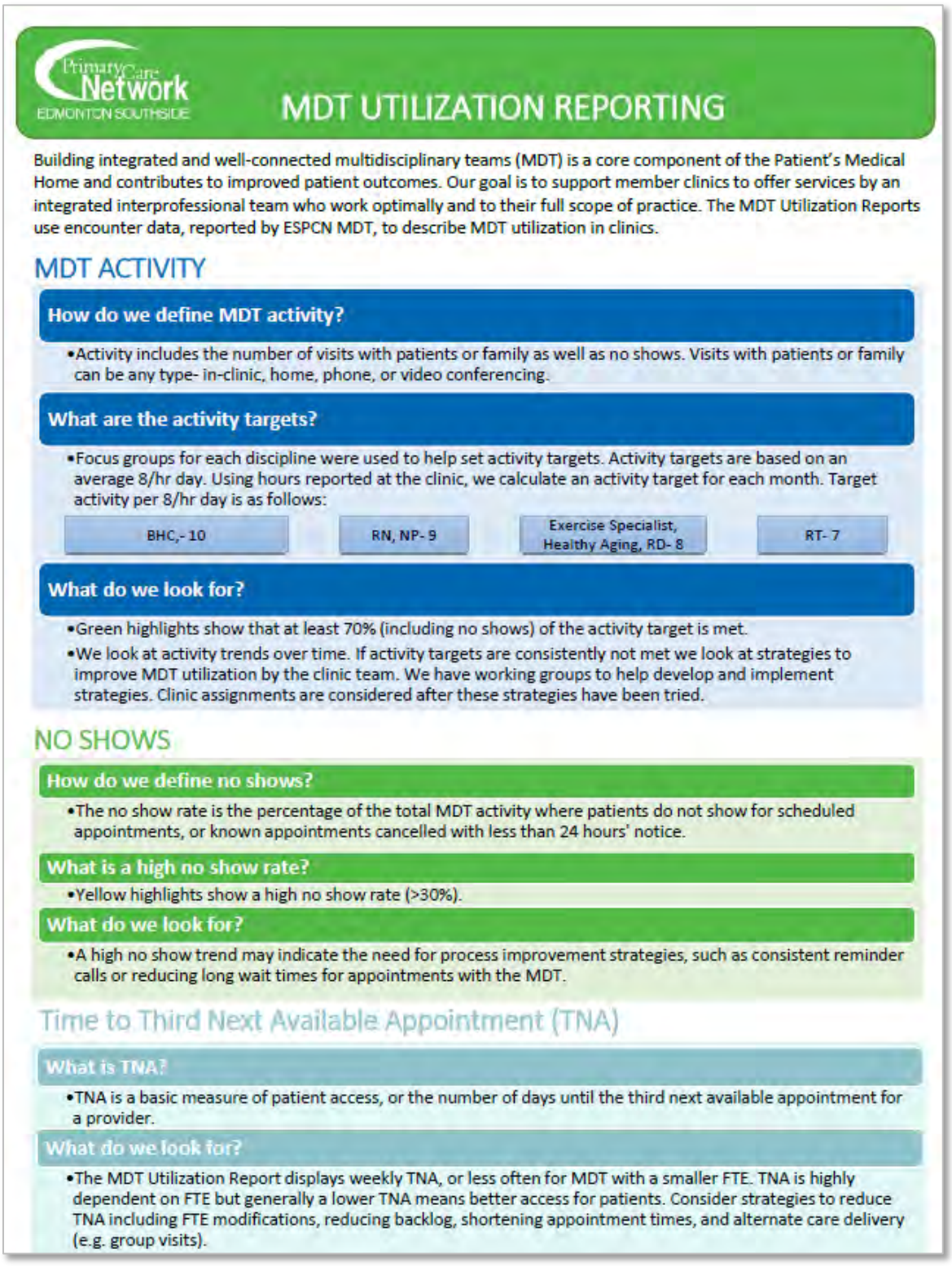
Appendix I: Transitions of Care Flow Chart

https://www.edmontonsouthsidepcn.ca/app/uploads/APPENDIX-I-Transitions-of-Care-Algorithm-Aug-2019.pdf



Appendix J: MDT Utilization Reporting

https://www.edmontonsouthsidepcn.ca/app/uploads/APPENDIX-J-Understanding-utilization-reports_25Nov20.pdf



Primary Care Network
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MDT UTILIZATION REPORTING

Building integrated and well-connected multidisciplinary teams (MDT) is a core component of the Patient's Medical Home and contributes to improved patient outcomes. Our goal is to support member clinics to offer services by an integrated interprofessional team who work optimally and to their full scope of practice. The MDT Utilization Reports use encounter data, reported by ESPCN MDT, to describe MDT utilization in clinics.

MDT ACTIVITY

How do we define MDT activity?

- Activity includes the number of visits with patients or family as well as no shows. Visits with patients or family can be any type- in-clinic, home, phone, or video conferencing.

What are the activity targets?

- Focus groups for each discipline were used to help set activity targets. Activity targets are based on an average 8/hr day. Using hours reported at the clinic, we calculate an activity target for each month. Target activity per 8/hr day is as follows:

BHC,- 10	RN, NP- 9	Exercise Specialist, Healthy Aging, RD- 8	RT- 7

What do we look for?

- Green highlights show that at least 70% (including no shows) of the activity target is met.
- We look at activity trends over time. If activity targets are consistently not met we look at strategies to improve MDT utilization by the clinic team. We have working groups to help develop and implement strategies. Clinic assignments are considered after these strategies have been tried.

NO SHOWS

How do we define no shows?

- The no show rate is the percentage of the total MDT activity where patients do not show for scheduled appointments, or known appointments cancelled with less than 24 hours' notice.

What is a high no show rate?

- Yellow highlights show a high no show rate (>30%).

What do we look for?

- A high no show trend may indicate the need for process improvement strategies, such as consistent reminder calls or reducing long wait times for appointments with the MDT.

Time to Third Next Available Appointment (TNA)

What is TNA?

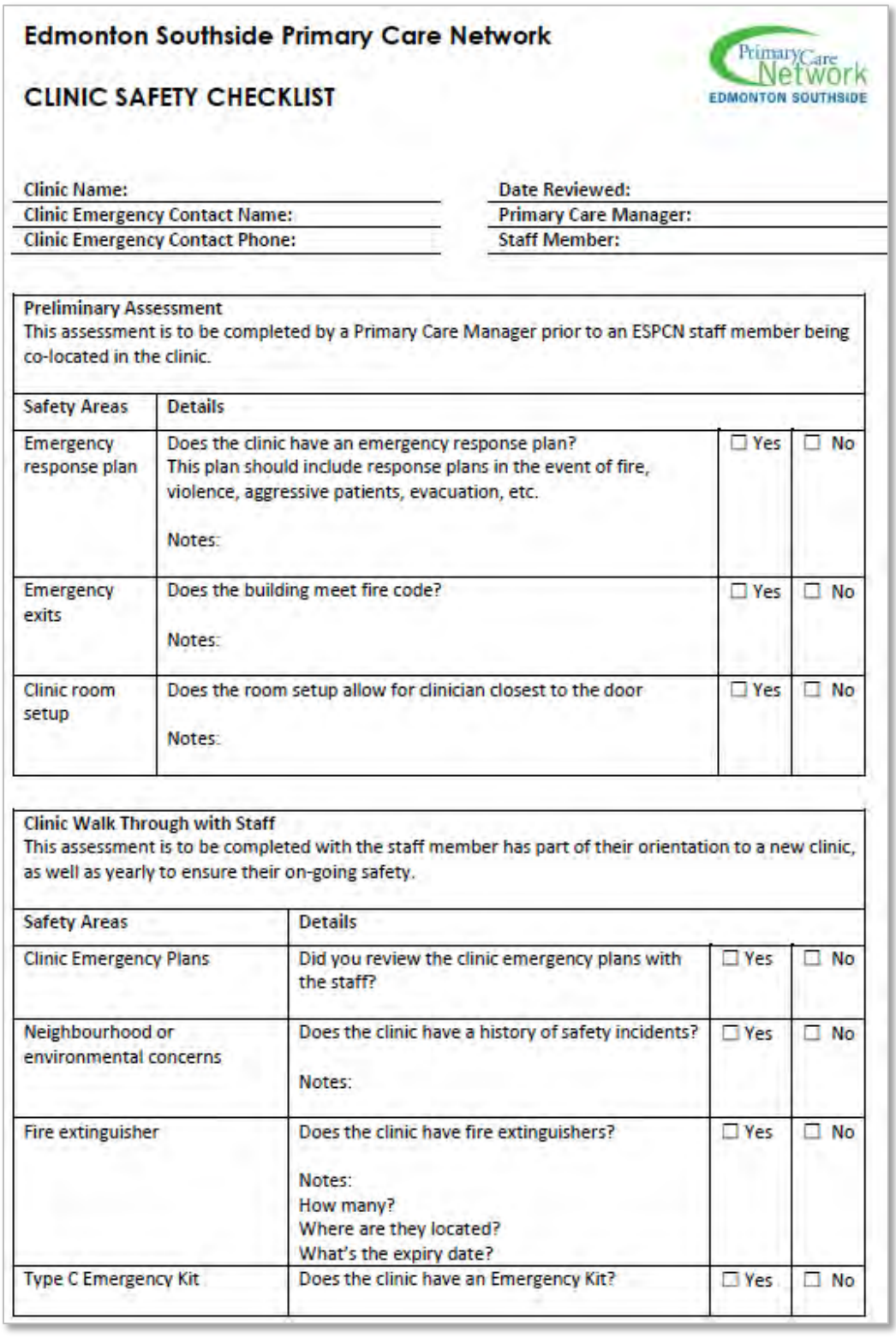
- TNA is a basic measure of patient access, or the number of days until the third next available appointment for a provider.

What do we look for?

- The MDT Utilization Report displays weekly TNA, or less often for MDT with a smaller FTE. TNA is highly dependent on FTE but generally a lower TNA means better access for patients. Consider strategies to reduce TNA including FTE modifications, reducing backlog, shortening appointment times, and alternate care delivery (e.g. group visits).

Appendix K: Clinic Safety Checklist

https://www.edmontonsouthsidepcn.ca/app/uploads/APPENDIX-K-Clinic-Safety-Checklist.pdf



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CLINIC SAFETY CHECKLIST

Clinic Name:	Date Reviewed:
Clinic Emergency Contact Name:	Primary Care Manager:
Clinic Emergency Contact Phone:	Staff Member:

Preliminary Assessment
This assessment is to be completed by a Primary Care Manager prior to an ESPCN staff member being co-located in the clinic.

Safety Areas	Details		
Emergency response plan	Does the clinic have an emergency response plan? This plan should include response plans in the event of fire, violence, aggressive patients, evacuation, etc. Notes:	☐ Yes	☐ No
Emergency exits	Does the building meet fire code? Notes:	☐ Yes	☐ No
Clinic room setup	Does the room setup allow for clinician closest to the door Notes:	☐ Yes	☐ No

Clinic Walk Through with Staff
This assessment is to be completed with the staff member has part of their orientation to a new clinic, as well as yearly to ensure their on-going safety.

Safety Areas	Details		
Clinic Emergency Plans	Did you review the clinic emergency plans with the staff?	☐ Yes	☐ No
Neighbourhood or environmental concerns	Does the clinic have a history of safety incidents? Notes:	☐ Yes	☐ No
Fire extinguisher	Does the clinic have fire extinguishers? Notes: How many? Where are they located? What's the expiry date?	☐ Yes	☐ No
Type C Emergency Kit	Does the clinic have an Emergency Kit?	☐ Yes	☐ No

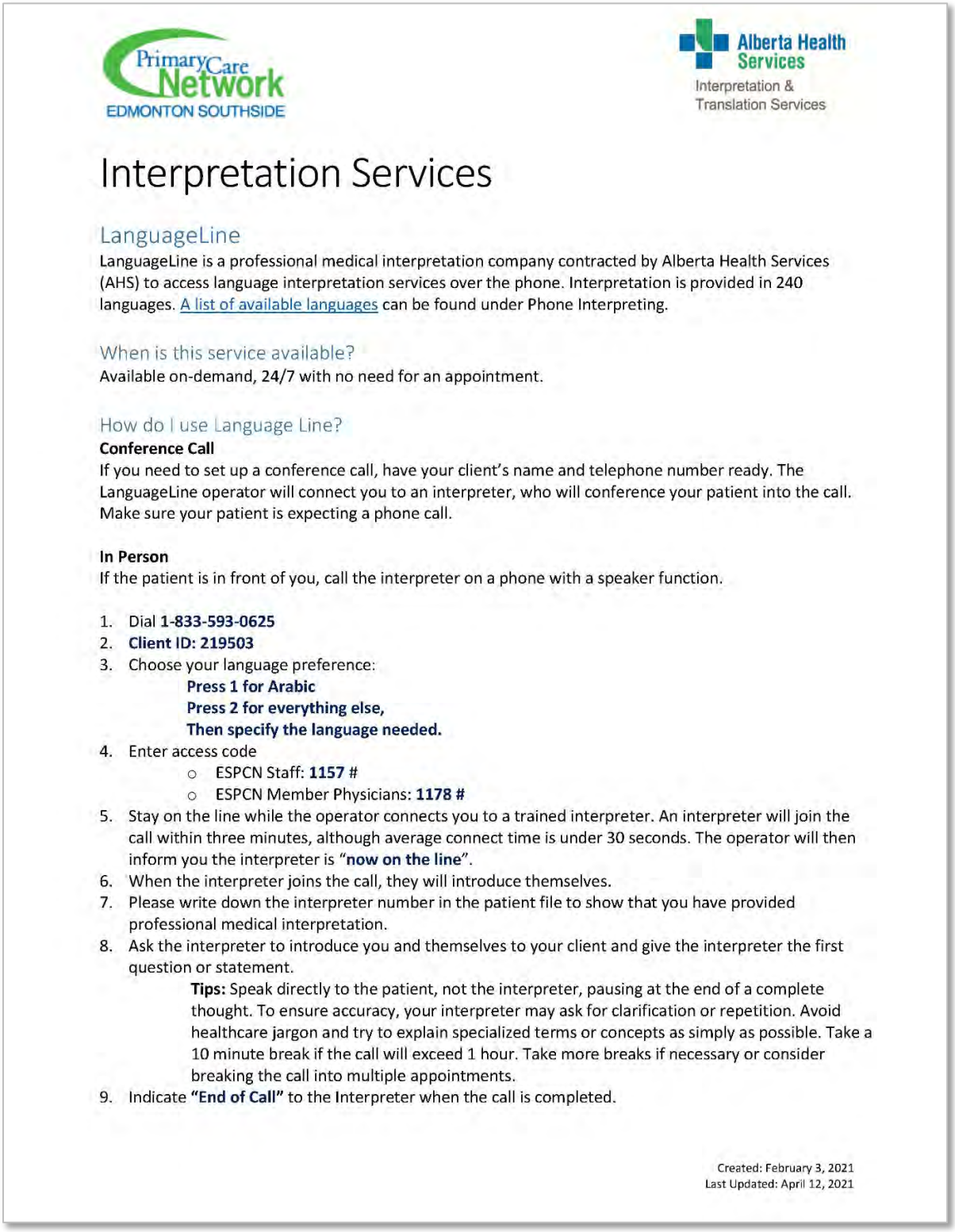
Edmonton Southside Primary Care Network

CLINIC SAFETY CHECKLIST

	Does the clinic have any of the following: ☐ On site medications ☐ Oxygen tank ☐ CPR equipment Notes:		
Muster point	Does the clinic have a designated muster point? Notes:	☐ Yes	☐ No
Safety/Policy Procedure Manual	Does the clinic have a Safety Policy and Procedure Manual? Notes:	☐ Yes	☐ No
Emergency alarm system	Does the clinic have an emergency awareness process? If yes, is it through the EMR or a clinic wide panic button? Notes:	☐ Yes	☐ No
Staff Panic Button	Has the staff received their personal panic button? Is the clinic aware of how to respond? Notes:	☐ Yes	☐ No
Clinic access	Does the clinic have the following: ☐ Locking doors ☐ Alarm system ☐ Keys/fobs for the PCN staff What time is the clinic open to be accessed? Will the ESPCN staff ever be expected to be on site alone? Notes:		

Appendix L: ESPCN Language Line Interpretation Services

https://www.edmontonsouthsidepcn.ca/app/uploads/APPENDIX-L-Language-Line-Interpretation-Services.pdf



Primary Care Network
EDMONTON SOUTHSIDE

Alberta Health Services
Interpretation & Translation Services

Interpretation Services

LanguageLine

LanguageLine is a professional medical interpretation company contracted by Alberta Health Services (AHS) to access language interpretation services over the phone. Interpretation is provided in 240 languages. A list of available languages can be found under Phone Interpreting.

When is this service available?

Available on-demand, 24/7 with no need for an appointment.

How do I use Language Line?

Conference Call

If you need to set up a conference call, have your client's name and telephone number ready. The LanguageLine operator will connect you to an interpreter, who will conference your patient into the call. Make sure your patient is expecting a phone call.

In Person

If the patient is in front of you, call the interpreter on a phone with a speaker function.

1. Dial **1-833-593-0625**
2. **Client ID: 219503**
3. Choose your language preference:
   Press 1 for Arabic
   Press 2 for everything else,
   Then specify the language needed.
4. Enter access code
   - ESPCN Staff: **1157 #**
   - ESPCN Member Physicians: **1178 #**
5. Stay on the line while the operator connects you to a trained interpreter. An interpreter will join the call within three minutes, although average connect time is under 30 seconds. The operator will then inform you the interpreter is "**now on the line**".
6. When the interpreter joins the call, they will introduce themselves.
7. Please write down the interpreter number in the patient file to show that you have provided professional medical interpretation.
8. Ask the interpreter to introduce you and themselves to your client and give the interpreter the first question or statement.
   Tips: Speak directly to the patient, not the interpreter, pausing at the end of a complete thought. To ensure accuracy, your interpreter may ask for clarification or repetition. Avoid healthcare jargon and try to explain specialized terms or concepts as simply as possible. Take a 10 minute break if the call will exceed 1 hour. Take more breaks if necessary or consider breaking the call into multiple appointments.
9. Indicate **"End of Call"** to the Interpreter when the call is completed.

Created: February 3, 2021
Last Updated: April 12, 2021