Primary Care Network
EDMONTON SOUTHSIDE

Physician Member Handbook

Edmonton Southside Primary Care Network

2023

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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 39 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://albertapcns.ca/pcn
[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

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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/training-events/pcn-governance-training/pcn-governance-training-essentials-accredited/

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://open.alberta.ca/publications/primary-care-initiative-policy-manual

- *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.

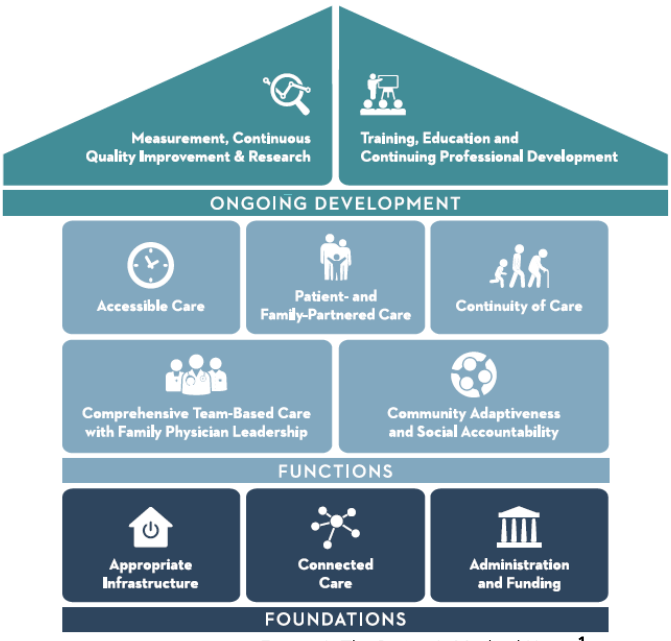


Figure 1. The Patient's Medical Home [1]

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/pmh/

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/why-pmh-and-getting-started/

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). 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 10% 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

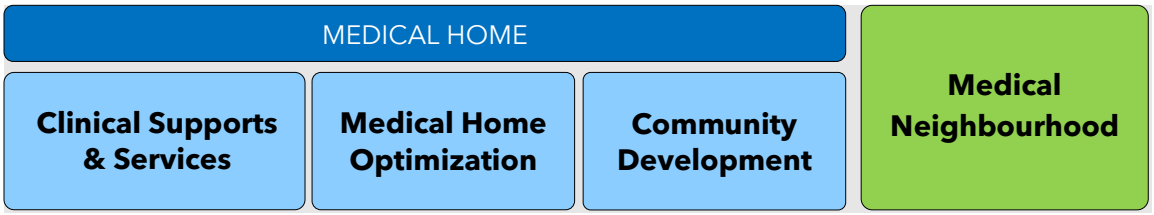
BUSINESS PLANNING & CORPORATE BUDGET

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.

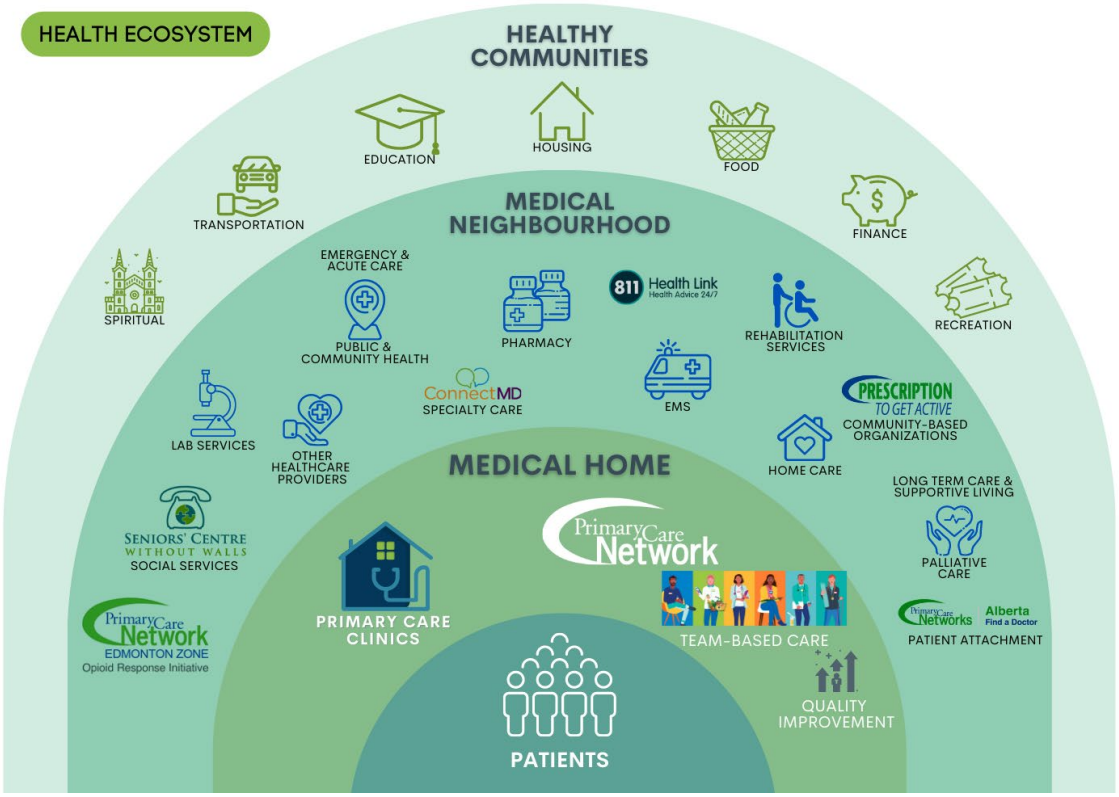
Medical Neighbourhood

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.

UPDATE



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

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. (See Appendix H: New Physician Flowchart).

UPDATE

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.

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.

Leaving a PCN

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 is process is set in place by AH and is non-negotiable and means that over the next 3 years, every 6 months the semi-annual patient panel funding amount will be readjusted for both PCNs. 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 to be completed 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 to join 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 to be 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.

3. Once your desire to end-date with ESPCN is confirmed, Alberta Health will send confirmation of your end-date with the 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.

Leaving the ESPCN to retire or move provinces

If a physician is a member of the ESPCN and wishes to join another PCN, the same rules apply as above. If you are closing your clinic, the College of Physicians & Surgeons of Alberta (CPSA) requires that you notify your patients so they may look for new health care providers. If you are leaving a clinic, you can connect with other physicians in your clinic to transfer your patient panel.

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 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 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 Proactive Care

Coordination Assistants) oversees the advancement of Medical Home initiatives throughout the PCN.

Communications Manager oversees the marketing and communication services for the ESPCN targeted towards employees, members, stakeholders and the public.

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.
- 

Proactive Care Coordination Assistants (PCCAs) are administrative staff who work "behind the scenes", using a clinic's EMR. PCCAs find patients who are due for care or screening, including patients who:
    - Are 75+ years of age
    - Have a chronic disease
    - Have not had an appointment in 3 years or more
    - Who are due for screening for: breast/cervical/colorectal cancer, diabetes, or plasma lipid profile.

  PCCAs call patients to offer an appointment with their physician or the appropriate MDT, or a screening requisition, depending on the process the clinic develops with their IF. The PCC program serves as a safety net to prevent vulnerable patients from falling through the cracks in our health system.

Multidisciplinary Team (MDT)

Since 2005 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)

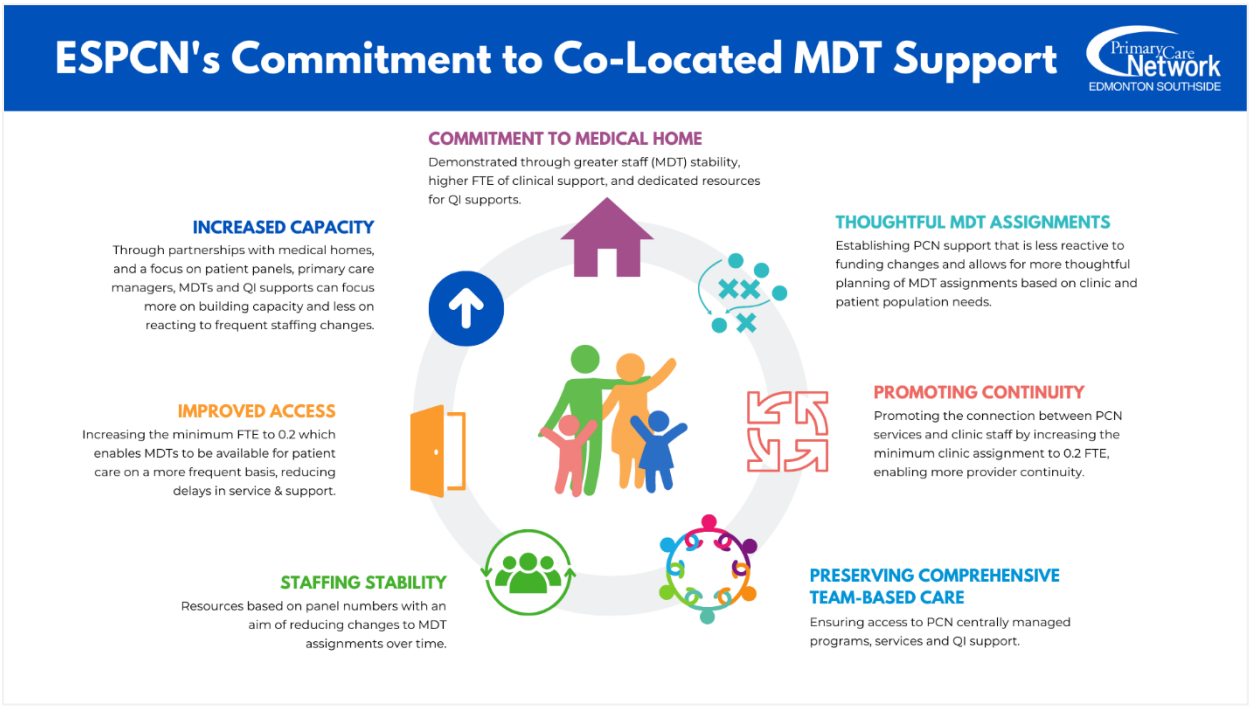
Primary Care Managers, in discussion with physician members and based on patient panel needs, determine which team members will be co-located into clinics.

- 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[12],
- Monthly PCN staff/discipline meetings,
- Ad hoc working groups/projects,
- Home visits.



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

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

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

BAND	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 $3,200 per 1.0FTE of MDT (clinicians), per month. There is no MDTOH payment attached to QI supports, including PCCAs.

- 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, access to clinic administration supports, such as MOAs and referral management, and the cost of medical supplies used by the MDT members. 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, access to administration supports, and required medical supplies. 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[13] 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.
- 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.

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

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.
- 

In alignment with Alberta Health billing standards[14], physicians cannot bill Alberta Health for care provided by MDT providers. Physicians and clinics cannot charge patients directly for any services provided by MDT providers.

Clinic Safety

The ESPCN Health and Safety Committee has developed a clinic safety toolkit[15] for our member clinics as a resource for community physicians and teams. This toolkit provides

[14] https://open.alberta.ca/dataset/0846c58f-75c1-448d-ab45-c4b3e386667f/resource/bac2c1b8-a42d-4991-b72f-70c0bb4dd27b/download/hlth-somb-medical-governing-rules-2023-04.pdf
[15] www.edmontonsouthsidepcn.ca/clinic-safety

clinics with tools to help prepare for, prevent, and respond to violent incidents. Workplace harassment and violence are potential hazards that may be encountered at work and are more common in health care than in other industries.

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.

The ESPCN would also use this toolkit when integrating MDT staff in order to address any safety concerns and ensure a safe working environment for ESPCN staff.

Safety considerations:

- In clinic safety plan review, including the clinic safety checklist and clinic tour
- Infection control as per CPSA standards[16]
- 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 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.

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

ESPCN PATIENT PROGRAMS & 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.

Referral Management Team

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. Once a referral is received at the ESPCN Central Office, a confirmation letter is sent back to the clinic to confirm receipt of the referral. Our referral assistants then process the referral and patients are called to book an appointment with a Central MDT member. Once the patient has been seen a consultation letter is sent back to the member physician. If a patient was unable to be booked into an appointment, a letter is sent back to the member physician to inform them that this was unable to be booked.

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.

Registered Dietitian Services

To expedite the timely access to RD services, patients are registered for a group visit, if available, based on the referral reason provided on the MDT referral form. Our referral management team uses defined criteria (Appendix M) to determine which referrals are appropriate for a group visit, a 1:1 RD appointment or to be contacted by an RD to better assess their needs.

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.[17] If you require workshop resources, please contact your Primary Care Manager.

Seniors' Centre Without Walls

Seniors' Centre Without Walls[18] (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[19] 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 also access a video interpreter on Zoom for American Sign Language. Language Line is available to all ESPCN member physicians and staff. 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)[20]. 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.

[17] https://www.edmontonsouthsidepcn.ca/workshops/
[18] https://www.edmontonsouthsidepcn.ca/scww/
[19] https://www.languageline.com/s/
[20] https://mchb.org/

NEW

ESPCN PROGRAMS & SERVICES AT A GLANCE

DR = Doctor Referral | NR = No Referral Required

EXERCISE

Assessment & Counselling	*DR*

WORKSHOPS

GLA:D Hip & Knee	*DR*
GLA:D Back	*DR*

HEALTHY AGING

Assessment & Counselling	*DR*

WORKSHOPS

Moving for Memory	*DR*
Senior Centre Without Walls	*NR*
Personal Directive & Enduring Power of Attorney	*NR*

NURSING SERVICES

Assessment & Counselling	*DR*
Lower Leg Assessment Clinic (LLAC)	*DR*

NUTRITION

Assessment & Counselling	*DR*

PSYCHIATRIST LINKAGES

Assessment	*DR*

MENTAL HEALTH

Mental Health Support	*DR*
Central Social Work Support	*DR*

WORKSHOPS

Changeways	*NR*
Emotional Regulation	*NR*
Happiness Basics	*NR*
Teen Anxiety	*NR*
Anxiety to Calm	*NR*

LUNG HEALTH

Assessment & Counselling	*DR*
COPD & Asthma Clinic	*DR*

WORKSHOPS

Breathing for Health	*DR*
QuitCore	*NR*

PREGNANCY

Assessment & Counselling	*DR*

WORKSHOPS

Group Prenatal	*NR*

Primary Care Network
EDMONTON SOUTHSIDE

If you are referring a patient for services, please fill out the ESPCN MDT Referral Form (and any required secondary forms). Please fax the form directly to Patient Intake at 780.435.5526.

NEW

Primary Care Network
EDMONTON SOUTHSIDE

GROUPS & WORKSHOPS OVERVIEW

EXERCISE

WORKSHOPS

GLA:D Hip & Knee

Education and exercise sessions for patients with hip or knee osteoarthritis.

GLA:D Back

A treatment option for individuals with persistent or recurrent low back pain that affects everyday life.

HEALTHY AGING

WORKSHOPS

Moving for Memory

For individuals noticing changes in their brain health such as cognitive impairment or dementia. Patients learn physical and memory exercises as part of steps towards a healthier brain.

Seniors' Centre Without Walls

Free phone-based program that offers a variety of interactive health and well-being information sessions, recreational activities and friendly conversation.

Personal Directive & Enduring Power of Attorney

For individuals who wish to complete their Personal Directives and Enduring Power of Attorney legal paperwork with insight from a medical perspective.

PREGNANCY

WORKSHOPS

Group Prenatal

For expecting parents who 20 weeks+ in their pregnancy. Parents learn about the stages of labour, comfort measures, pharmaceutical options and discuss medical interventions with trained professionals.

LUNG HEALTH

WORKSHOPS

Breathing for Health

A pulmonary rehabilitation program for individuals with COPD providing COPD and healthy lifestyle education including supervised exercising.

QuitCore

Offers tools, strategies and skills needed to quit using tobacco for good.

MENTAL HEALTH

WORKSHOPS

Changeways

For individuals who need help to combat stress, anxiety and depression.

Emotional Regulation

For individuals who have difficulty controlling their emotions or feels that their behaviour is causing problems in their life.

Happiness Basics

For individuals who need help to boost their overall happiness. Patients learn mindfulness techniques and how to incorporate pleasure into day-to-day activities.

Teen Anxiety

Designed for teens ages 13-17 to combat anxious feelings and behaviours. Patients will learn how to identify symptoms related to anxiety and ways to cope using physical movement, nutrition, and other practical strategies.

Anxiety to Calm

For adults (18+) who struggle with anxiety and wants to learn skills to help manage anxiety. Patients will learn ways to manage their anxiety, challenge their thoughts, behaviours, and emotions, as well as improve their lifestyle.

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 PCCA 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[21] stands for Community Information Integration (CII) and Central Patient Attachment Registry (CPAR). CII is a provincial mechanism to integrate community EMRs with

[21] https://www.albertanetcare.ca/learningcentre/CII-CPAR.htm

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. ESPCN Improvement Facilitators can provide more information on CII/CPAR adoption at the ESPCN.

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[22] 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

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

team members are instrumental in setting the direction of program evaluations including the framework design, interpretation of results, and generating recommendations.

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[23] (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[24], 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

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

this reason, we encourage physicians/clinics to provide guidance and training to ESPCN-employed staff on clinic-specific privacy and security policies and procedures.

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[25].

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.

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

- 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

Physician Portal

The physician portal is a secure online space where you will find information for ESPCN member physicians including access to UpToDate. You can access the Physician Portal by visiting www.edmontonsouthsidepcn.ca and clicking on "Physician Portal" on the top right of the screen. Information on your login credentials is given when you become a member. If you do not a username/password assigned or you need to update your password, please contact communications@espcn.ca.

UpToDate

UpToDate[26] 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[27] 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[28] 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[29] (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

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

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 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@espcn.ca.

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 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 10% 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 and Open Houses

These events are held throughout the year focusing on a variety of topics that affect physician members. Stay tuned to our monthly clinical newsletter for more information on these events.

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[30].

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[31].

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.

[30] https://edmontonsouthsidepcn.us18.list-manage.com/subscribe?u=800fd35196b5607c4cd0205ee&id=421f510647
[31] https://www.albertadoctors.org/services/programs/pls/job-board

Webinars & Workshops

The ESPCN has partnered with the Physician Learning Program (PLP)[32] to offer a number of educational opportunities for members and their teams throughout the year. Past topics have included CII/CPAR, heart failure, COPD, ADHD, lung health, and opioid dependency. You will find information on these opportunities in our monthly clinical newsletter or via email from the ESPCN.

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 Jacquie MacLean, Executive Assistant to the Executive Director at Jacquie.MacLean@espcn.ca
- For information on events and website access, contact communications@espcn.ca

[32] https://www.albertaplp.ca/

UPDATE

DEFINITIONS

ACTT	Accelerating Change Transformation Team
AFAD	Alberta Find a Doctor
AGM	Annual General Meeting
AH	Alberta Health
AHPC	Alberta Health Physician Consent form
AHS	Alberta Health Services
AMA	Alberta Medical Association
BHC	Behavioural Health Consultant
BOD	Board of Directors
BPA	Business Plan Amendment
CD	Clinical Director
CFPC	College of Family Physicians of Canada
CII/CPAR	Community Information Integration and Central Patient Attachment Registry
COAL	Central Office Admin Lead
CPSA	College of Physicians and Surgeons of Alberta
ED	Executive Director
EMR	Electronic Medical Record
EMR-C	Electronic-Medical Record Consultant
ES	Exercise Specialist
ESPCN	Edmonton Southside Primary Care Network
EZ	Edmonton Zone
FTE	Full-Time Equivalent
HIA	Health Information Act
HR	Human Resources

HUTV	Health Unlimited TV
IF	Improvement Facilitator
IMA	Information Management Agreement
ISA	Information Sharing Agreement
LLAC	Lower Leg Assessment Clinic
LOP	Letter of Participation
LPN	Licensed Practical Nurse
MCHB	Multi-Cultural Health Brokers
MD	Medical Director
MDT	Multidisciplinary Team
MDTOH	Multidisciplinary Team Overhead
MH	Medical Home
MOA	Medical Office Assistant
NP	Nurse Practitioner
NPC	Not-For-Profit Corporation
OIPC	Office of the Information and Privacy Commissioner
OT	Occupational Therapist
PAC	Physician Advisory Committee
PCC	Proactive Care Coordination
PCCA	Proactive Care Coordination Assistant
PCI	Primary Care Initiative
PCIC	Primary Care Initiative Committee
PCM	Primary Care Manager
PCN	Primary Care Network
PIA	Privacy Impact Assessment
PMH	Patients Medical Home

QI	Quality Improvement
RD	Registered Dietitian
RHA	Regional Health Authority
PCRN	Primary Care Registered Nurse
RT	Respiratory Therapist
SW	Social Worker

APPENDICES

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

(https://open.alberta.ca/publications/primary-care-initiative-policy-manual)

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://open.alberta.ca/publications/primary-care-initiative-policy-manual)

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://open.alberta.ca/publications/primary-care-initiative-policy-manual)

(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

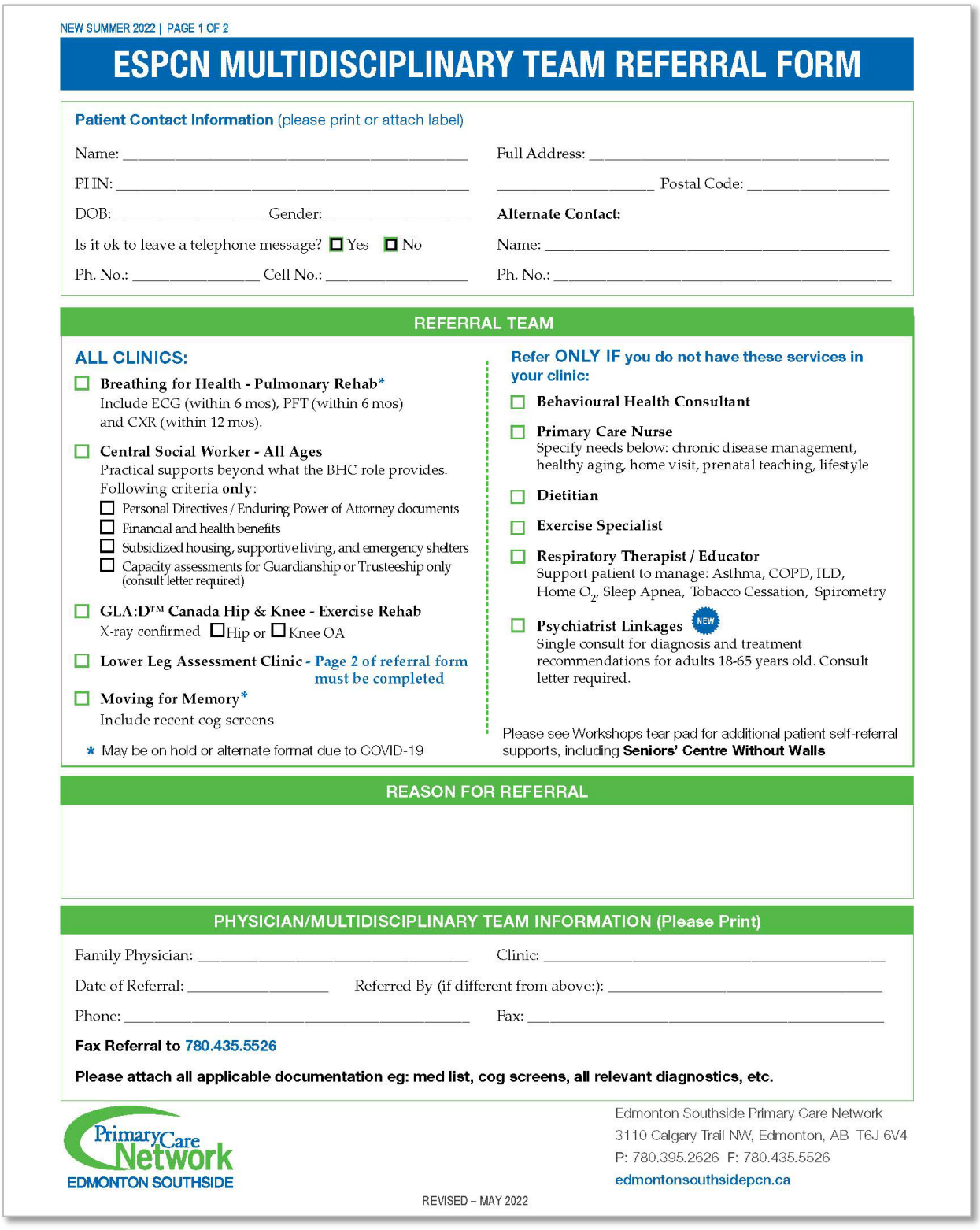
PCNs are governed by the following policy document created by Alberta Health. Revised in March, 2018.

(https://actt.albertadoctors.org/pmh/clinic-enablers/practice-supports/pcn-operational-resources/)

- 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

UPDATE

Appendix F: MDT Full Scope Listing

REGISTERED NURSE SCOPE

Who is a Primary Care Registered Nurse?

A core member of the primary care team, the primary care registered nurse (PCRN) is an autonomous provider who works collaboratively with primary care physicians and the multidisciplinary team to provide comprehensive nursing services and care to patients in primary care. Primary care registered nurses provide holistic, patient-centred care across the lifespan with a goal of improving health outcomes and facilitating access to services. PCRN visits may be done in the clinic or in patient's homes and are often carried out independently and leverage the use of medical directives and protocols to promote independent, autonomous practice. And the PCRN role may vary based on panel and population needs. PCRNs also participate in quality improvement in the clinic setting to advance the Medical Home.

Primary Care Registered Nurse provides the following care:

Holistic Assessment, Care Planning, and Care Coordination:

- Transitions of care hospital discharge follow up
- Systematic follow up and support to manage specific patient populations
- Assessment and intervention related to the social determinants of health
- Medication review

Health Promotion and Education:

- Preventative health education and screening, including pap tests
- Communicable disease screening and education, including immunizations
- Sexual and reproductive health visits (which can include birth control and STI screening)
- Prenatal and postpartum education and care
- Family care and well child visits
- Healthy aging assessment including cognitive screening

Chronic Disease Management (proactive and systematic):

- Basic lifestyle changes (nutrition, exercise)
- Diabetes including insulin starts and adjustment
- Cardiovascular risk, heart failure, hypertension
- Dyslipidemia
- Asthma, COPD, smoking cessation
- Weight management
- Chronic pain
- Mental Health – depression, anxiety

Other Activities (less than 20% of PCRN time in clinic):

- Triage and phone advice
- Clinical tasks:
    - Injections (medications, allergy immunotherapy, immunizations)
    - Ear syringing
    - Wart treatments
    - Dressing changes
- INR monitoring and warfarin dose adjustments

NURSE PRACTITIONER SCOPE

Who is a Nurse Practitioner?

A nurse practitioner (NP) is a health professional with a master's degree in nursing who can provide essential health care services in the medical home. Nurse practitioners are independent, autonomous health professionals and require no outside supervision of their practice. Nurse practitioners practice uniquely by viewing health of the whole person, with emphasis on education, communication, and disease prevention. 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
- Refer directly to specialists and specialty programs

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?

A behavioural health consultant is an allied health professional, usually a registered social worker, registered nurse or registered psychiatric nurse, that works collaboratively with primary care physicians and the multidisciplinary team to address chronic disease and mental health concerns through evidence-based behavioural interventions. Any patient whose health is impacted by habits, behaviours, thoughts, and stress or emotional concerns that get in the way of daily life and/or overall health would benefit from a referral to a behavioural health consultant.

The behavioural health consultant works with patients on their physical, behavioural and emotional concerns and helps to come up with a plan that works best for them. BHCs offer solution-focused care with an emphasis on skill building, development of coping strategies, and patient self-management of their chronic diseases and mental health through evidence-based behavioural interventions.

How is this different from Specialty Mental Health?

The BHC is part of the multidisciplinary team. They will provide consultation and brief intervention, as opposed to traditional psychotherapy. This service is not the same as counselling or therapy and should not be promoted as such. The aim of BHC services is to focus on symptom reduction and teaching self-management, as opposed to resolving the patient's concern.

What is the difference between a BHC, a Psychologist and a Psychiatrist?

- BHCs: help with habits, behaviours, stress, or emotional concerns that get in the way of daily life and/or overall health.
- Psychologists: assess, diagnose, and treat mental health problems and disorders. Psychologists have an advanced degree like a master's degree or PhD. A psychologist can take you through specialized tests to help diagnose emotional or cognitive function.
- Psychiatrists: medical doctors who can diagnose mental illnesses. Unlike psychologists or BHCs, psychiatrists can prescribe medications to help treat mental illness.

A Behavioural Health Consultant can provide support for patients experiencing the following concerns:

- Stress

- Anger
- Depression
- Family/relationship problems
- Anxiety or worries
- Financial Strain and Community Navigation
- Grief/bereavement
- Substance use
- Post-traumatic stress (PTSD)
- Medical problems, such as: hypertension, insomnia/sleep disturbance, chronic pain, fibromyalgia, headaches, gastrointestinal problems (GERD, IBS), diabetes, asthma, COPD, sexual dysfunction
- Lifestyle changes: A BHC can work with the patient to create a plan for quitting smoking, weight management, exercise, or other lifestyle changes.

What happens in a BHC appointment:

- Appointments are 30 minutes maximum. Patients may average between 4-6 appointments per concern. Patients are asked about physical symptoms, emotional concerns, behaviors, and how these might be related to one another.
- The BHC will complete a solution focused functional assessment and assist to develop a behavioral care plan with the patient and their healthcare team.

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 having a better health care experience within their medical home.
- Patients are empowered to take more control of their overall health.
- Preventing acute health concerns from turning into chronic concerns.
- Development of better health literacy related to their health concerns.
- Leveraging the entire team to support a patients overall health.

REGISTERED DIETITIAN SCOPE

Who is a Registered Dietitian?

A registered dietitian (RD) is a regulated allied health professional uniquely trained to advise on food and nutrition for overall health and wellness. RDs provide nutrition counselling using motivational interviewing, problem solving and cognitive behavioral strategies. They are qualified to provide medical nutrition therapy for the prevention, delay and management of disease. RDs work collaboratively with physicians and the multidisciplinary team. RDs also participate in, and lead QI initiatives related to primary care or Medical Home optimization.

Nutrition services from a Registered Dietitian can help patients:

- Eat according to their individual body's hunger and fullness levels
- Learn how to eat properly to support their metabolism and unique body needs
- Eat to maximize energy levels and manage food cravings
- Develop self-management skills to take control of their own treatment and manage their own health

Patients can benefit from RD support for the prevention and management of a variety of health conditions including:

- CDM (Dyslipidemia, DM, HTN, fatty liver disease, kidney failure, chronic kidney disease, COPD, obesity)
- Micronutrient concerns (bone health/osteoporosis, low iron, nutrient deficiencies, post bariatric surgery etc.)
- Digestive disorders (Crohn's, UC, IBS, IBD, GERD, celiac disease, diverticular disease)
- Malnutrition (pediatric FTT, seniors, cancer, malabsorptive disorders)
- Disordered eating behaviour (emotional eating, binge eating, etc.)
- Nutrition through the lifespan (picky eating, child and adolescent growth and development, prenatal/maternal nutrition, healthy aging, etc.)
- Specific dietary patterns (vegan, vegetarian etc.)
- Food allergies/sensitivities/intolerances
- Anxiety, depression and other mental health disorders
- Nutrition to support physical activity
- Food security

What does working with a Registered Dietitian look like?

Our registered dietitians provide nutrition education, counselling and medical nutrition therapy through group visits, individual appointments and workshops. At the central ESPCN clinic, referrals are directed to the most appropriate RD service using defined criteria based on reason for referral.

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 Clinical Exercise Physiologist™ (CEP) through the Canadian Society for Exercise Physiology (CSEP).

Who can Exercise Specialists work with?

Research literature[33] 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
- Immunological 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?

ESs support patients in group settings and also in individual appointments including:

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 regulated allied health care professionals who are skilled in assessing, monitoring, and managing people living with a respiratory disease. The role of primary care respiratory therapists is to participate in the planning, implementation, and evaluation of respiratory care plans. RTs are knowledgeable about the current treatment guidelines and medications for COPD and asthma and can help provide guidance on inhalers and adjunct therapy. They perform in-office pre and post-bronchodilator spirometry

[33] 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.

tests to assess the effectiveness of treatment plans and monitor disease progression. Spirometry may also be used to aid in diagnosis if one has not been made yet.

Respiratory therapists provide education and disease management strategies for any respiratory disease, counseling on smoking cessation, review of respiratory medication with a demonstration of proper inhaler device techniques, and development of action plans. All the PCN RTs are also certified respiratory educators (CRE). This credential recognizes healthcare professionals who provide evidence-informed respiratory care and education to their patients, including education in both asthma and COPD.

RT's recognize that there can be challenges and barriers for those with lung disease. They work with the patient to individualize care and disease management, as well as help to connect patients with additional resources and support as appropriate. RTs offer home-visits where indicated or where they may be barriers to a patient visiting in clinic.

What services do RTs provide?

- Assessment and management of respiratory symptoms and/or diseases
- Provide patient self-management education on lung disease based on current treatment guidelines
- COPD and Asthma action plans
- Spirometry Testing (pre and post bronchodilator), oximetry, and 6-minute walk tests
- 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
- Coordinate care with MDT or community supports (home oxygen, sleep testing/CPAP therapy, etc.)
- Provide lung health education to PCN MDT and other healthcare providers

What does working with a Registered Therapist look like?

- Comprehensive assessments, both initial and follow up.
- Ongoing RT support to assess improvement following a medication trial, assess medication compliance, or to monitor any disease progression. Follow ups are also provided for recent exacerbations, smoking cessation counselling and disease education and management.

COPD & Asthma Clinic

Patients with a diagnosis of COPD and/or asthma will automatically be enrolled in the PCN COPD & Asthma Clinic, which provides lifetime access to regular follow ups to monitor

disease management and progression, regular spirometry testing and personalized respiratory care.

REGISTERED SOCIAL WORKER SCOPE

Who is a Social Worker?

A registered social worker is a regulated allied health professional who supports patients of all ages to identify and access appropriate services, through collaboration with other professionals within the multidisciplinary team. Social workers engage people and communities to address life challenges and build resiliency by providing practical supports related to the social determinants of health.

At ESPCN the registered social workers provide services out of the central ESPCN clinic or via home visits where indicated. The central social worker (CSW) sees patients from 0-64 years while the healthy aging social worker (HASW) sees patients from 65years and above.

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.
- Prepare or complete personal directives, enduring power of attorney documents
- Provide 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.
- Review of seniors supportive living options, financial supports, benefits, and pension information pertinent to seniors (includes filling out application forms for certain benefits).
- Family violence support, including support for elder abuse.

What is the Referral Process?

ESPCN physician and MDT members can refer to the CSW or the HASW on the central referral form.

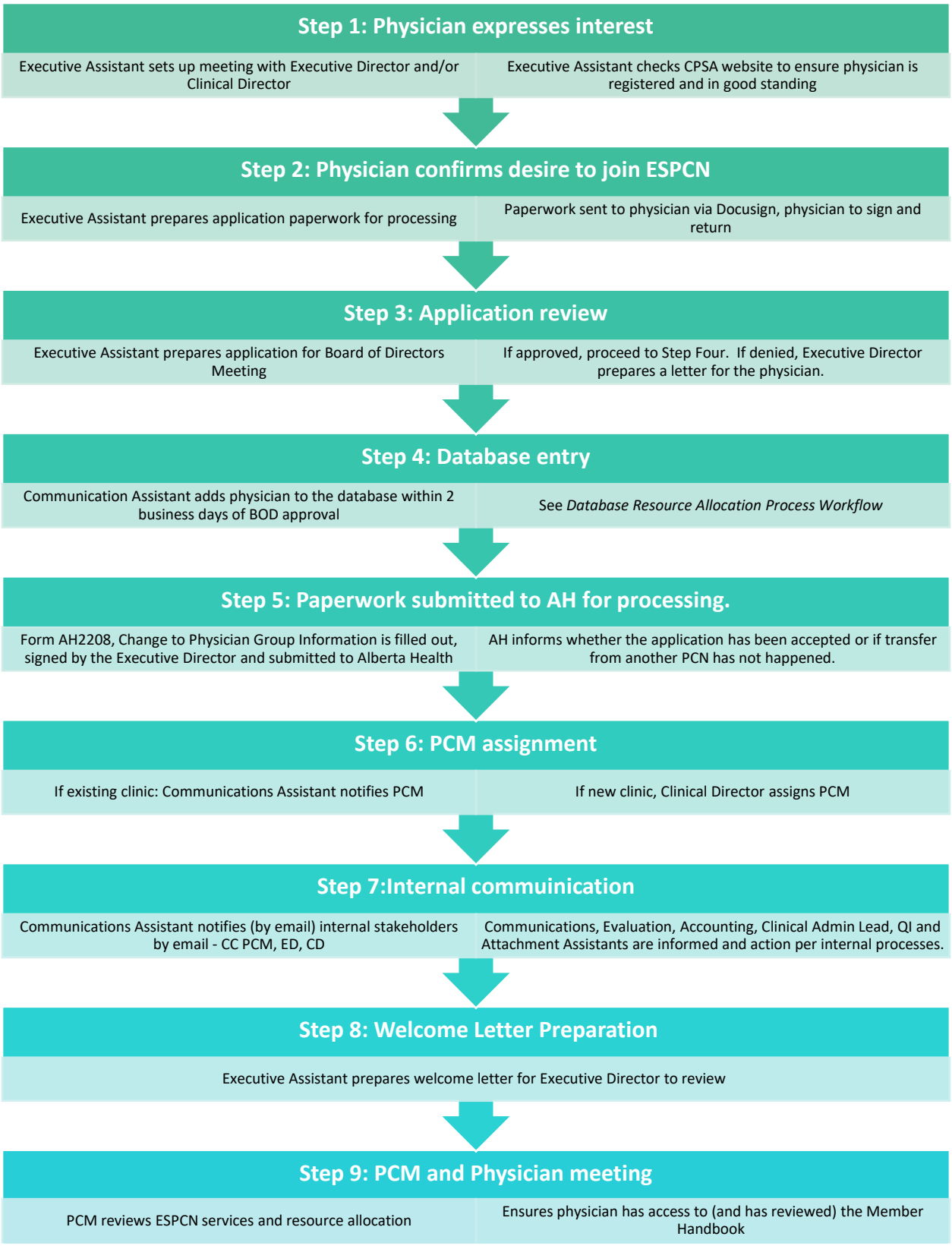
Appendix G: Schedule B - Primary Health Care Indicator Set

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

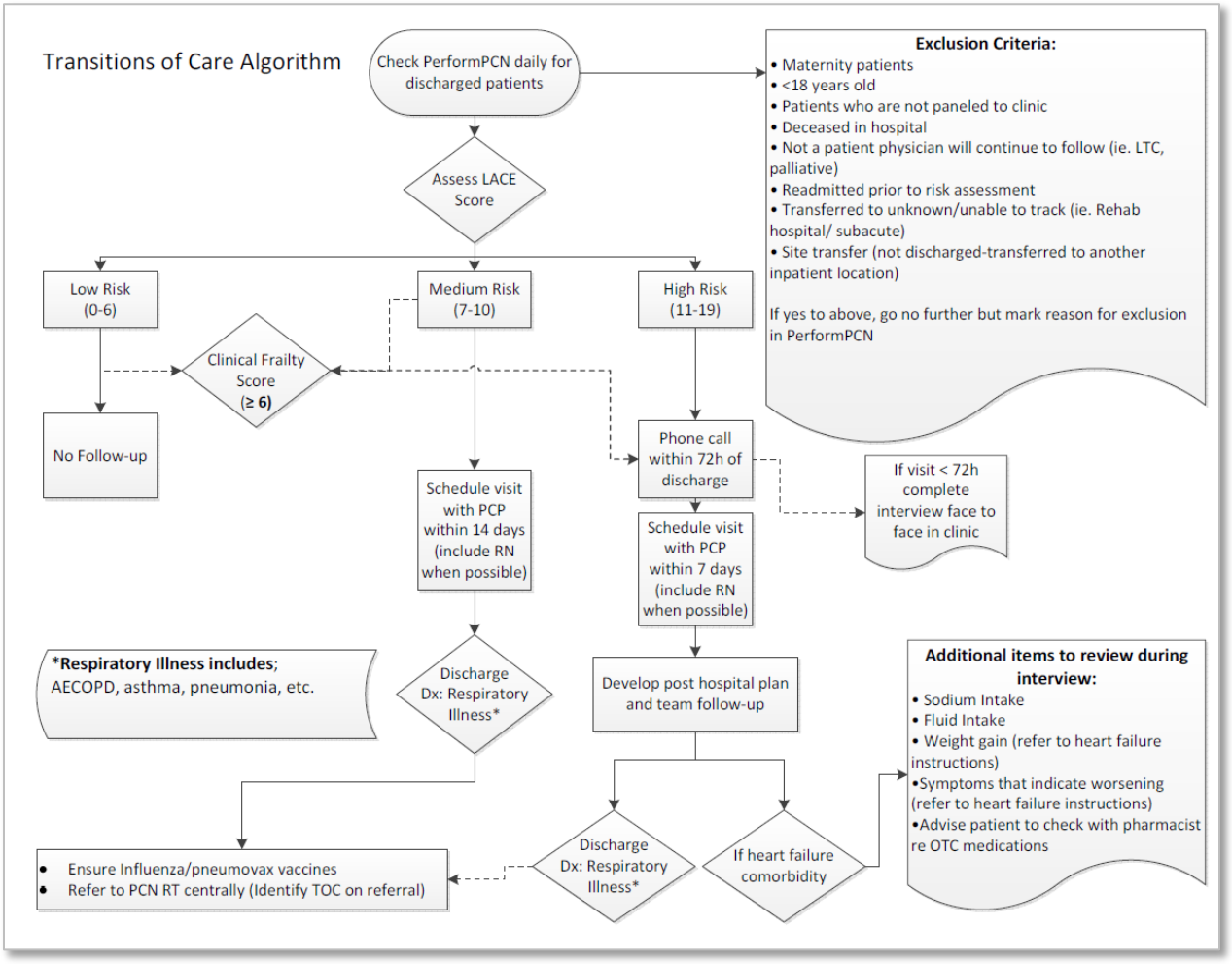
UPDATE

Appendix H: New Physician Flowchart



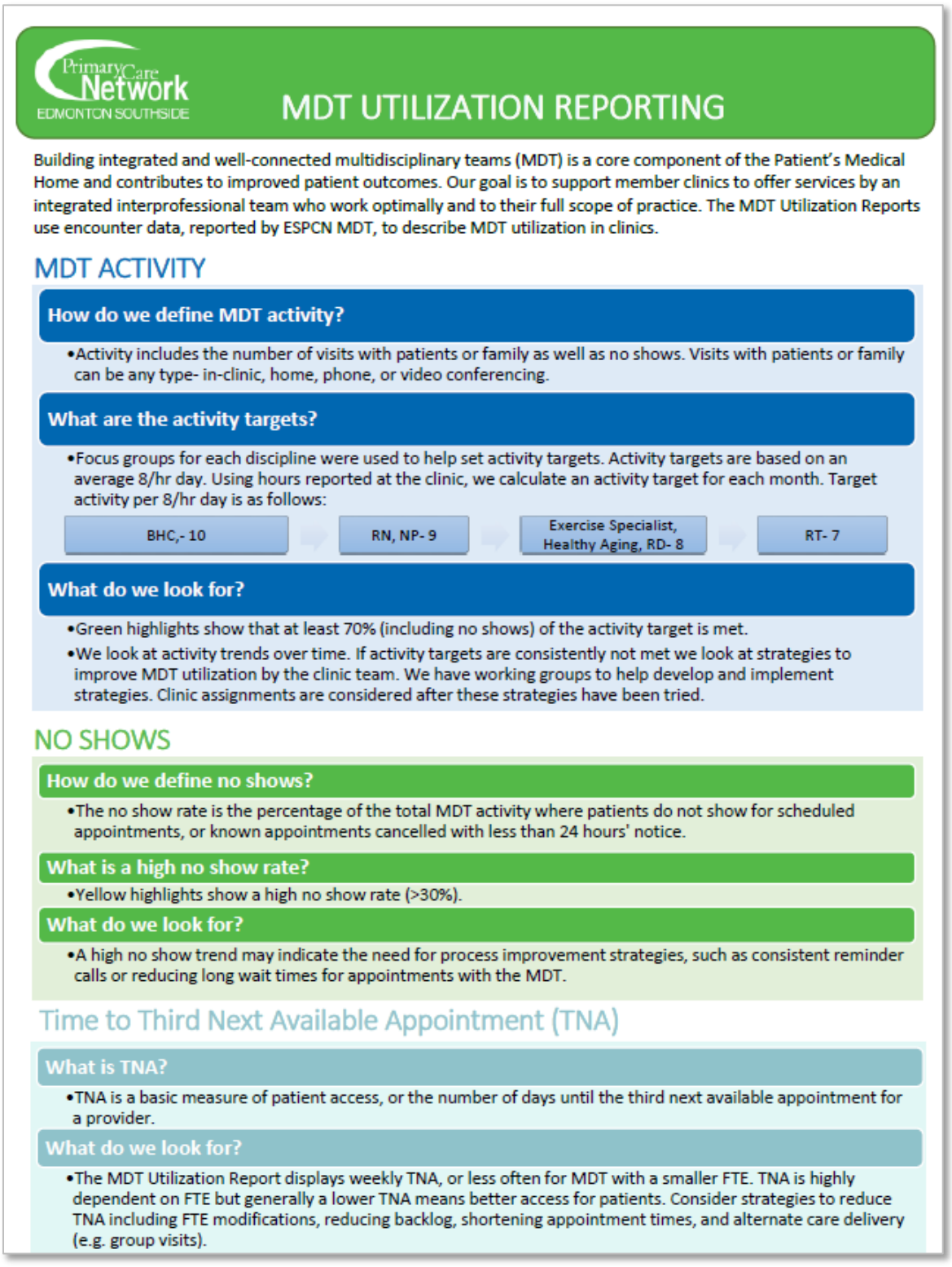
Appendix I: Transitions of Care Flow Chart

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
EDMONTON SOUTHSIDE

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?

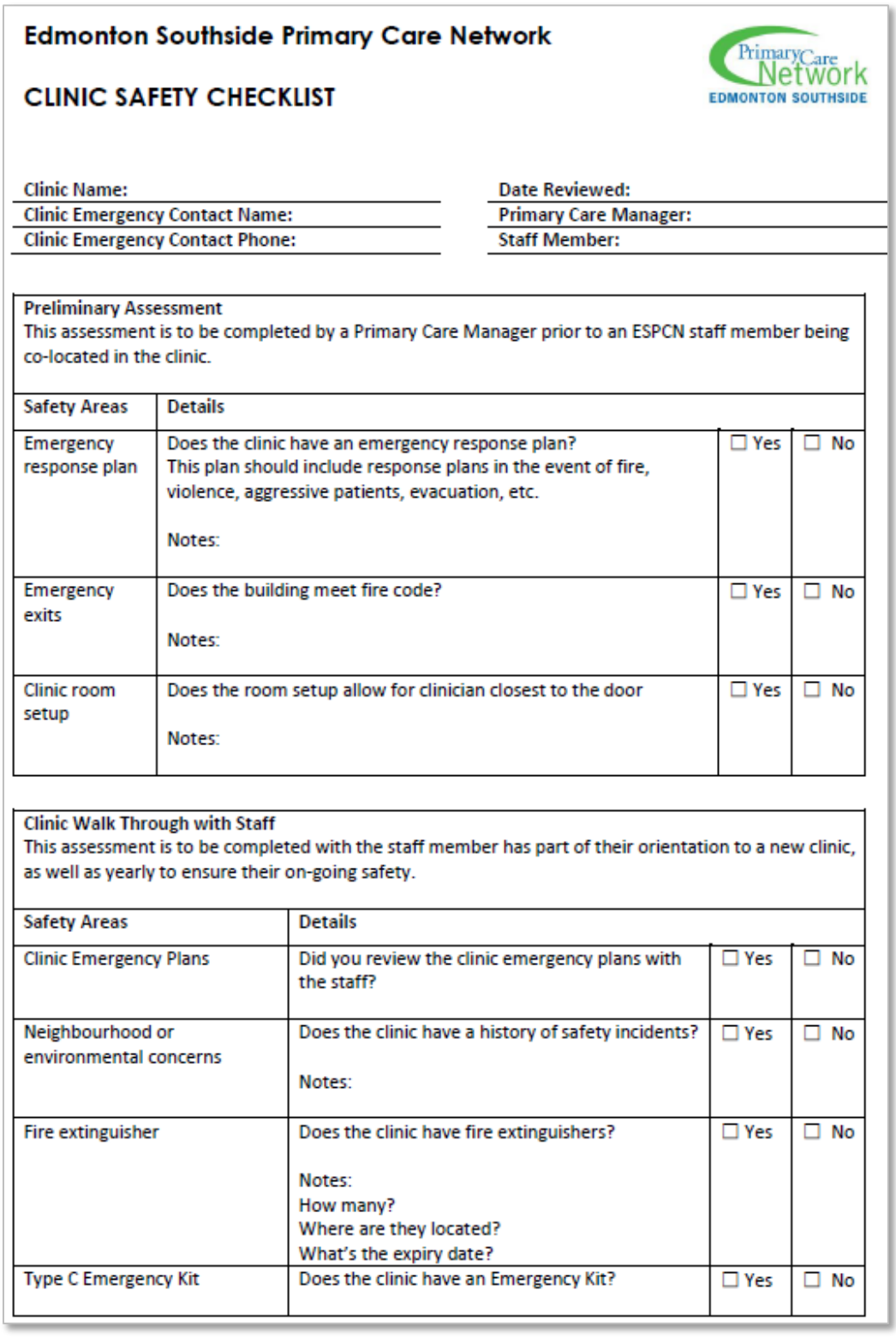
- TNA is a basic measure of patient access, or the number of days until the third next available appointment for a provider.

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:		

UPDATE

Appendix L: ESPCN Language Line Interpretation Services

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

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INTERPRETATION & TRANSLATION SERVICES

Language Line

The Language Line is a professional medical interpretation company contracted by Alberta Health Services to access language interpretation over the phone or video conferencing. Interpretation is provided in 240 languages and is available on demand, 24/7 with no appointment needed.

HOW DO I USE LANGUAGE LINE?

Conference Call

If your patient is at home, you can have the interpreter set up a three-way call.

- Make sure the patient is expecting a phone call
- Have your client's name and telephone number ready.

In Person

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

Video Conference

- **Skype:** Set up your Skype call as you would normally do. Then click on the Invite More People Button shown here. Enter the Language Line number.
- **Zoom:** It is possible to connect with Zoom if you are using a professional license for Zoom and you have a hosted account. In order to connect with Zoom, you will require a separate number: if you would like to access this option, please contact translation.services@ahs.ca.
- **Other:** Install the *LanguageLine App* on your device to quickly connect to professional interpreters anytime. Complete a one-time activation of your device. The authentication code for ESPCN is **JDWJ9HJHWB** and device name is **ESPCN**.

1. Dial **1-833-593-0625**
2. **Client ID: 219503**
3. Choose language:
   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 until the operator connects you to a trained interpreter. This will be within three minutes, although average connect time is under 30 seconds.

- When the speaker joins the call, they will introduce themselves. Please write down the interpreter number in the patient file to show that you have provided professional medical interpretation.
- Ask the interpreter to introduce you and themselves to your client and give the interpreter the first question or statement.
- Indicate "**End of Call**" to the interpreter when the call is completed.

NEW

Appendix M: Central RD Triage Flow Chart

https://www.edmontonsouthsidepcn.ca/app/uploads/APPENDIX-M-Central-RD-Triage-Flow-Chart.pdf

CENTRAL RD TRIAGE FLOW CHART

When a referral for RD services received at the central office, that referral is processed by a referral team member.

If referral fits into any of the following 4 buckets of criteria, the referral team member will contact patient and book:

1:1 RD Appointment

- Patients <18 y.o.
- Prenatal nutrition/pregnancy
- Language barrier
- Food allergies / intolerance
- Irritable bowel syndrome / FODMAP / bloating/gas
- Inflammatory bowel disease / Crohn's Disease / colitis / ulcerative colitis
- Diverticulitis / Diverticular
- Anemia / low iron
- Osteoporosis / bone health
- Type 1 diabetes
- CKD (chronic kidney disease)
- GERD / heartburn / reflux
- Disordered eating
- Gout
- Weight loss surgeries (gastric bypass, sleeve, etc.)

RD Group Visit (Diabetes)

- Elevated / high blood sugar / glucose
- Prediabetes
- Type 2 diabetes
- A1c indicated
- Diabetes management

RD Group Visit (Healthy Eating)

- Hypertension / high blood pressure
- Dyslipidemia
- Hypercholesterolemia
- High cholesterol
- Elevated lipids / cholesterol
- Weight management / obesity
- Fatty liver
- Healthy eating

Phone Triage Appointment

- No referral reason
- Multiple conditions listed
- "On insulin" is indicated
- Referral is ambiguous

Clinician will contact the patient during the appointment & book the patient for services as appropriate.

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