2024

Physician Member Handbook

Edmonton Southside Primary Care Network

Primary Care Network
EDMONTON SOUTHSIDE

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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.

39 PCNs are 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 that 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 on 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.

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

[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
[5] https://www.albertadoctors.org/Leaders-Primary%20Care/PCN_report_FINAL_acfp_web.pdf

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 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

[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/
[8] https://open.alberta.ca/publications/primary-care-initiative-policy-manual

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 details 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.

- *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.

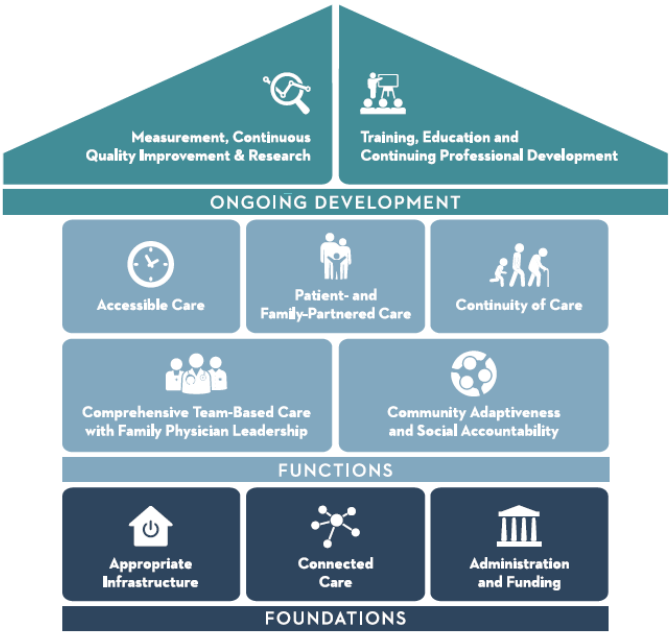


Figure 1. The Patient's Medical Home [1]

The PMH is a family practice defined by its patients as the place where 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 the 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/

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, has 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.

[11] https://actt.albertadoctors.org/pmh/why-pmh-and-getting-started/

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 not 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 can be re-elected, but may only serve for a maximum of 3 consecutive terms. (Articles of Association, 12.5).

The BOD is 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

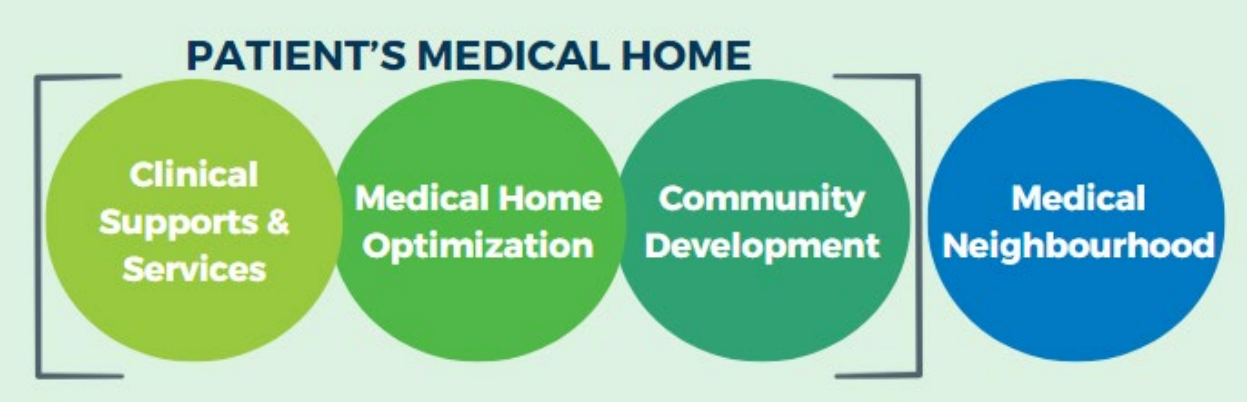
BUSINESS PLANNING & CORPORATE BUDGET

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 2024-2027 Business Plan, the ESPCN will continue to operate in four priority areas:



Clinical Services and Supports

The ESPCN's multidisciplinary team (MDT) enables team-based care and 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 patient's needs.

Medical Home Optimization

The ESPCN helps our members with the advancement of the patient's medical home. The ESPCN will continue to expand on quality improvement expertise (through improvement facilitators, EMR consultants, and proactive care coordination assistants) to provide our members with meaningful, sustainable, and continuous improvement implementation.

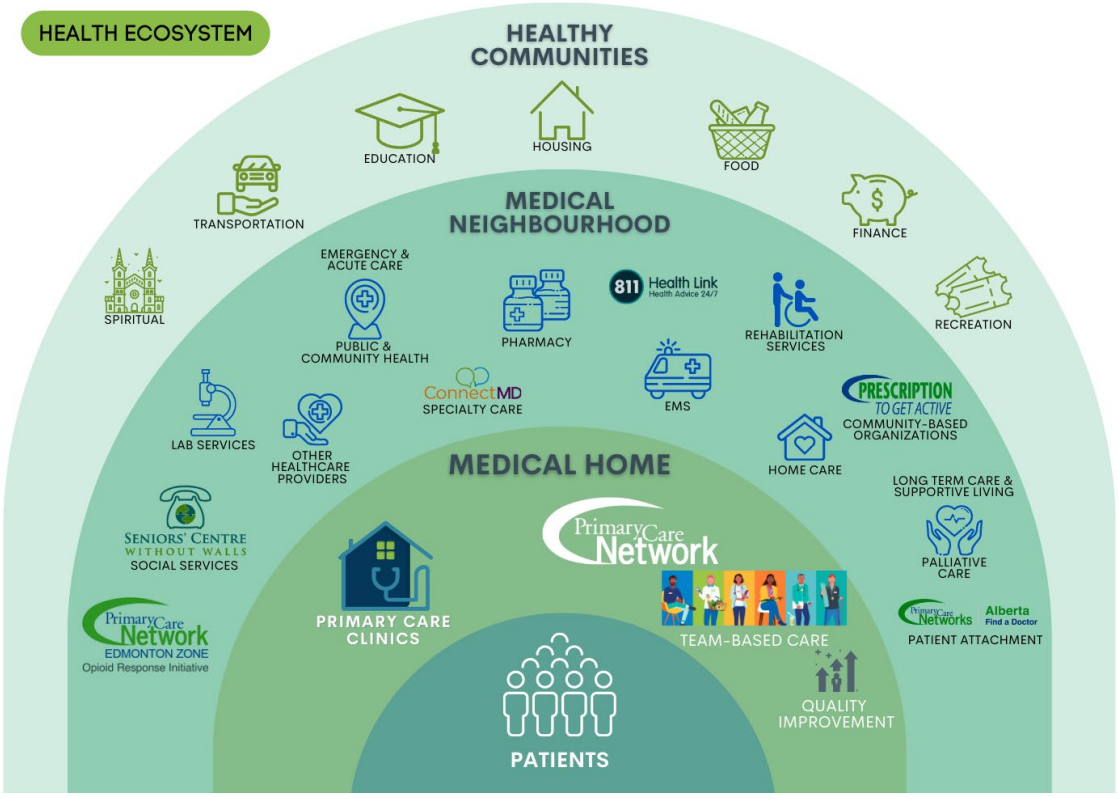
Community Development

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.

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



Corporate Budgeting

Yearly Budgeting

The ESPCN's fiscal year runs from April 1 to March 31 and the ESPCN's official budget is due to AH at the end of March. Budgeting begins in October and an early draft is presented at the January board meeting. Each year, AH requires that the PCN use panel numbers released in late February as the basis for the revenue for the subsequent year's budget. A finalized budget is presented to the Finance and Audit Committee and the Board in 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
- Payments to Member Clinics – Rev. Mar. 16, 2016 Policy
- Payments to Physicians for MDT Care & Overhead Policy

PHYSICIAN MEMBERSHIP

Physician Membership Policy

The ESPCN, in accordance with paragraph 3.1.4 of its Joint Venture Agreement, has the right and responsibility to "establish any eligibility or other prerequisites which must be met by physicians to become or remain participating physicians." Participating physicians are physicians who, or whose professional corporation, have signed a letter of participation with 1157178 Alberta Ltd.

The Physician Membership (Appendix N) policy describes the process by which the ESPCN will proactively review and consider physicians who wish to join the ESPCN, the acceptance criteria for prospective physicians, and the responsibilities and expectations of participating physicians. The most recent revision to this policy was approved by the Board in April 2023. This policy contributes to the ESPCN's ability to manage operations and successfully deliver approved programming to participating physicians within the limitations of the funding model and the current business plan.

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 with ESPCN, and physicians are then entered into our internal membership database (see Appendix H: New Physician Flowchart). Only family physicians and pediatricians are eligible to be members of PCNs in Alberta.

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 up for membership with the PCN, including all relevant membership forms and documentation, they are demonstrating their agreement to participate in the three-year business plan for that 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 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 process is set in place by AH and is non-negotiable which 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.

The 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.

The 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.

The 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, 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.

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.

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

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

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

The 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 the health outcomes of our patients. Our team of healthcare providers each plays 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 is 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.

Quality Improvement (QI) Team

Improvement Facilitators (IF) facilitate quality improvement meetings, support clinic teams to set new processes and goals, and assist in the 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.

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 apply 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 that the same staff member will return 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.

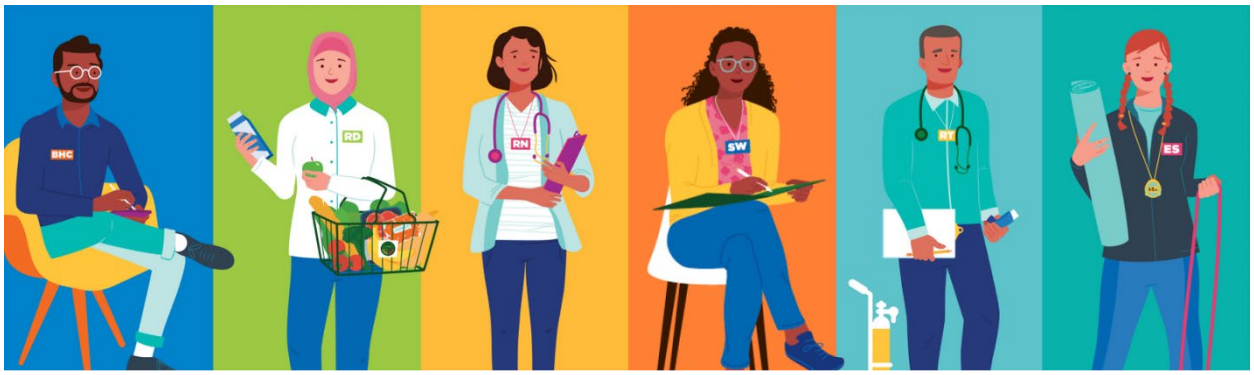
Staff Diversity

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 care services. All voices and experiences are needed when we pursue the diverse ideas and perspectives that allow us to serve our patients respectfully and with dignity. Our staff come from a variety of backgrounds and speak over 20 different languages, which in turn helps us serve our diverse patient population.

ESPCN strives to foster and maintain a diverse and inclusive workplace and promote a culture in which our differences are recognized and valued. We are committed to a working environment free from discrimination, bullying, or harassment. The ESPCN EDI committee, which was set up in 2021, focuses on advancing our understanding of equity, diversity, and inclusion within the organization. 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 within the clinic space.

Zero Tolerance

Edmonton Southside Primary Care Network is committed to fostering a safe, harassment-free workplace where all employees are treated with respect and dignity. Violence and harassment at the ESPCN or towards ESPCN staff will not be tolerated.



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 to 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 co-located MDT teams working with family physicians.

Team-based care is supported by the ESPCN through the hiring, management, and support of the following MDT: Primary Care Registered Nurse (PCRN), Nurse Practitioner (NP), Exercise Specialist (ES), Registered Dietitian (RD), Respiratory Therapist (RT), Behavioural Health Consultant (BHC - may be a Nurse or Social Worker), and Social Worker (SW). Read more about ESPCN Patent Programs and Supports including Mental Health Services, Central Clinic Services, and Patient Workshops in the next section.

The goal for the ESPCN MDT is to have all disciplines working to their full scope and ensure 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 teamwork.
- 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 the 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 that, prior to PCNs inception in Alberta, were already part of a clinic's staffing complement (e.g., MOAs, referral coordinators, LPNs, etc.). 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 physicians 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 the activity of health care providers and calculate the number of patients seen, patient access to care, no-show rates, and types of visits. This information is then used to produce utilization reports that can inform resource allocation and identify opportunities to improve care. An overview of MDT Utilization Reporting can be found in Appendix J.

Primary Care Managers and physician members review this data twice a year to ensure clinicians are well utilized, and functioning to full scope, as well as to help determine the 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

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

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.

Co-located MDT Support Allocations

Every six months, the ESPCN receives a panel calculation from Alberta Health based on the 4-cut method. The ESPCN receives $62 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 operational costs.

Physician clinics are placed into bands of 800 based on the patient panels as reported by AH. The band in which a clinic falls 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. ESPCN considers several factors when determining which supports a clinic is eligible for including patient population needs, existing services, and available MDT.

PCN central services (PCRN, RT, BHC, SW, RD, ES) are available to physicians who do not have co-located staff working in their clinic. Support for Medical Home Optimization is available to all clinics, including access to QI resources (IFs and EMR-Cs) and Proactive Care Coordination Assistants (PCCAs).

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

New physicians receive in-clinic support 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 in mid-January and mid-August.

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

- Multi-physician practice: The physician panel can be moved from one ESPCN clinic to another at the same time 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. Panel numbers are released semi-annually and are updated in April and in October. FTE and MDTOH are re-examined at that time.

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 on which entity will receive this payment.
- The ESPCN requests electronic payment information for ease of payment processing.
- Clinics may choose to waive their MDTOH to secure additional clinician FTE based on the respective resource allocation bands mentioned above.

Inclusions & Exclusions

The MDTOH includes coverage for the 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 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 support, 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 the initial set-up (if not already existing in the designated ESPCN space) of an 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 setup (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

MDTOH Payments

MDTOH payments are automatically generated based on the clinical FTE placed in the clinic. Before receiving any payments, the clinic must provide a GST declaration which determines if GST should be applied to the payment or not. Payments are made monthly, usually in the first two weeks of the month for the month prior.

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 cancelled.

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 (MDT staff must have autonomy over the use of the space and be able to book patients for any time within the allocated FTE).
- EMR access with a unique login (including remote EMR access).
- Equipment: computer, printer, and phone access (ESPCN can assist with initial setup).
- 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 procedures, 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. The performance of some patient visit activities requires physician presence as specified in the Medical Directives. ESPCN employees may be in the 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[13], 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 has developed a Clinic Safety Checklist (Appendix K) which enables Primary Care Managers to assess and address the safety of clinic environments for co-located MDT members. The assessment includes a component that is completed with the clinic prior to integrating ESPCN MDT members and a clinic walk-through during MDT member orientation. The checklist may also be used to reassess safety in clinics where there are existing MDT members on an annual basis.

Alberta Occupational Health and Safety requires employers to take measures to eliminate hazards where possible. If it is not reasonably practicable to eliminate the hazard, it is required to put controls

[13] https://open.alberta.ca/publications/somb-2024-04-01/resource/0a2e3168-0203-4f5c-a93f-6984bef8110a

in place to mitigate it. The number one thing that can be done to prevent workplace violence is to have a plan.

The ESPCN Health and Safety Committee has developed a clinic safety toolkit[14] for our member clinics as a resource for community physicians and teams. This toolkit provides clinics with tools to help prepare for, prevent, and respond to violent incidents. Workplace harassment and violence are potential hazards that may be encountered at work and are more common in health care than in other industries.

ESPCN is committed to working in partnership with member physician clinics to address any identified safety concerns. There may be areas of clinic safety that need to be resolved before an MDT member is integrated to ensure a safe working environment for ESPCN MDT 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 the 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.

ESPCN PATIENT PROGRAMS & SUPPORTS

Mental Health Services

Supported Therapy

The Supported Therapy Pilot was designed for patients with complex mental health needs requiring psychological services that would otherwise be inaccessible due to prohibitive cost and/or the absence of non-insured health benefits.

[14] https://www.edmontonsouthsidepcn.ca/clinic-safety/

Any member physician or ESPCN multidisciplinary team (MDT) member can identify a mental health concern for a patient. Once a mental health concern is identified, the patient can be referred to a behavioural health consultant (BHC), either co-located in their clinic or through the central office.

The BHC will assess the patient for eligibility and need based on three inclusion criteria:

- Household income less than $100,000 annually.
- Lack of access to non-insured benefits covering therapy.
- Demonstrated readiness and motivation for counselling.

If the patient fits the inclusion criteria, they will receive up to six fully subsidized counselling sessions with a registered psychologist or registered provisional psychologist through Cornerstone Counselling. When these sessions are completed, the patient may consent to have a treatment summary sent to their physician. This summary aims to promote continuity of care while respecting the patient's autonomy in disclosing sensitive issues. Additionally, after the cessation of supported therapy, the patient may be offered access to ongoing therapy per Cornerstone Counselling's policies or may continue to see the PCN Behavioural Health Consultant for ongoing behavioural support. The patient will be offered appropriate follow-up and/or additional services through the PCN and/or Cornerstone Counselling (access to sliding-scale options).

If the patient does not meet the inclusion criteria, they can continue to work with a BHC to self-manage symptoms and/or identify appropriate resources for additional support. In the case of non-readiness, patients will work with the BHC to develop motivation and set goals for counselling.

Psych Linkages

Psych Linkages is an arrangement between ESPCN member clinics and participating psychiatrists. This program has been operational at the Edmonton Southside Primary Care Network since September 2007. The Psych Linkages Program provides one-time consultations with a psychiatrist to assist physicians with psychiatric diagnoses, medication, and treatment recommendations for patients aged 18-65. This program can be accessed through a referral on the Central PCN Referral Form along with a referral letter. If the referring physician has questions or would like to connect with the psychiatrist after the one-time consult, they can email psychlinkages@espcn.ca.

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 PCRN, 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. If there is a waitlist, both the member physician

and the patient will receive a letter advising them that their referral was received, but they are on a waitlist. Referrals are currently processed on the same day as they are received. Patients are called twice in an effort to book their appointments. If a patient is 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. Once the patient has been seen, a consultation letter is sent back to the member physician.

To avoid issues with referrals:

- Include all required documentation. For example:
    - Breathing for Health: ECG, PFT, CXR
    - Psych Linkages: referral letter
- Ensure patient meets eligibility requirements, such as age
- Select all relevant checkboxes
    - For Lower Leg Assessment Clinic referrals, page 2 of the referral form must be completed
- It is helpful to include notes specific to patient needs
    - e.g., nurse - chronic disease management, prenatal, etc.

Central MDT

Member physicians that do not have co-located MDT in their clinic can refer to the central MDT that consists of PCRN, BHC, SW, RD, ES, RT, and Psychiatrist using the ESPCN referral form in Appendix E. For referrals to centrally-located providers to be accepted, the referring physician must provide information to the PCN about any changes to or additions to clinic practice locations, as stated in the Physician Membership Policy (Section 3.1). This ensures that communication between the physician practice (medical home) and central clinic services is maintained.

Lower Leg Assessment Clinic

The Lower Leg Assessment Clinic (LLAC) is an 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 for 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.[15] If you require workshop resources, please contact your Primary Care Manager.

Seniors' Centre Without Walls

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

Translation Services

LanguageLine[17] is a professional medical interpretation company contracted by AHS to access language interpretation services over the phone or video. Interpretation is provided in 240 languages and is available on-demand, 24/7 with no need for an appointment. You can 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)[18]. MCHB aims to bridge the gap between newcomer families and Canadian society, serves 23 cultural/language communities, and has various programs from perinatal health, youth initiatives and seniors outreach and offers holistic support. They connect families with health programs with a culturally and linguistically relevant approach.

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

ESPCN PROGRAMS & SERVICES AT A GLANCE

FOR ESPCN PHYSICIAN MEMBERS INFORMATION ONLY

Updated March 2024

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 (1-1 and Group Appointments)	*DR*

MENTAL HEALTH

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

WORKSHOPS

Changeways	*NR*
Emotional Regulation	*NR*

LUNG HEALTH

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

WORKSHOPS

Breathing for Health	*DR*

PREGNANCY

Assessment & Counselling	*DR*

WORKSHOPS

Group Prenatal	*NR*

PSYCHIATRIST LINKAGES

Assessment	*DR*

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.

Primary Care Network
EDMONTON SOUTHSIDE

Primary Care Network
EDMONTON SOUTHSIDE

GROUPS & WORKSHOPS OVERVIEW

Updated March 2024

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.

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.

LUNG HEALTH

WORKSHOPS

Breathing for Health

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

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.

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.

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 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[19] stands for Community Information Integration (CII) and Central Patient Attachment Registry (CPAR). CII is a provincial mechanism to integrate community EMRs with two-way data flow through Alberta Netcare. CPAR is a provincial system that captures the confirmed relationship between a primary provider and their panelled 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.

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

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 with 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 be displayed in Alberta Netcare in the demographic area of the patient's record.

QI Annual Plan

The ESPCN 2024-2027 business plan includes support for clinics to develop quality improvement plans. Your PCN quality improvement team can support you to develop an annual improvement plan and provide practical implementation support to help you meet your goals. Quality improvement plans are becoming more and more common across the PCNs, the zones, and the province. In addition, CPSA's Physician Practice Improvement Program[20] will also require practices to incorporate practice improvement activities in the near future.

Evaluation

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

Program Evaluation

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

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.

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

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

PRIVACY & HEALTH INFORMATION

Health Information Act (HIA)

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

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

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

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 the 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 by 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 (IMA) and Information Sharing Agreement (ISA).

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

Information Manager Agreement (IMA)

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

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

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

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

Information Sharing Agreement (ISA)

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

In the case of a health information privacy breach that occurs when the ESPCN is in possession of and responsible for the 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

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

- There are a number of privacy consultants operating in Alberta that can also support PIA development. Please reach out to the ESPCN Privacy Officer if you would like assistance finding an appropriate consultant for your practice.

ESPCN Lead Custodian Role

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

ESPCN Privacy Officer Role

- Oversees the ESPCN central clinic privacy and security and ensures compliance with the HIA.
- Responds to third-party requests for patient health information contained in the ESPCN central EMR.
- Supports member physicians and clinics related to privacy matters as required related to the 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 have a username/password assigned or you need to update your password, please contact communications@espcn.ca.

UpToDate

UpToDate[24] is an evidence-based resource medical professionals trust to find clinical answers quickly and easily. There are more than 12,000 topics in 25 specialties, continually updated and reviewed by leading experts. Connect to UpToDate through their Mobile App[25] or on any computer. The ESPCN

[24] https://www.uptodate.com/home/product
[25] https://www.uptodate.com/home/how-access-uptodate

provides this subscription-based service to all physician members and ESPCN staff for free. In order to maintain uninterrupted access to UpToDate, you must re-verify your affiliation with the ESPCN once every 90 days by logging in[26] through the Physician Login on the ESPCN website. Please contact your Primary Care Manager to get access.

Alberta Find a Doctor

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

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 who 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 on 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 offer 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, the infection prevention and control manual, etc. The Committee consists of ESPCN senior

[26] https://www.edmontonsouthsidepcn.ca/wp-login.php
[27] https://albertafindadoctor.ca/

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[28].

Physician Locums

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

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

ESPCN Website

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

Webinars & Workshops

The ESPCN has partnered with the Physician Learning Program (PLP)[30] 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

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

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
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

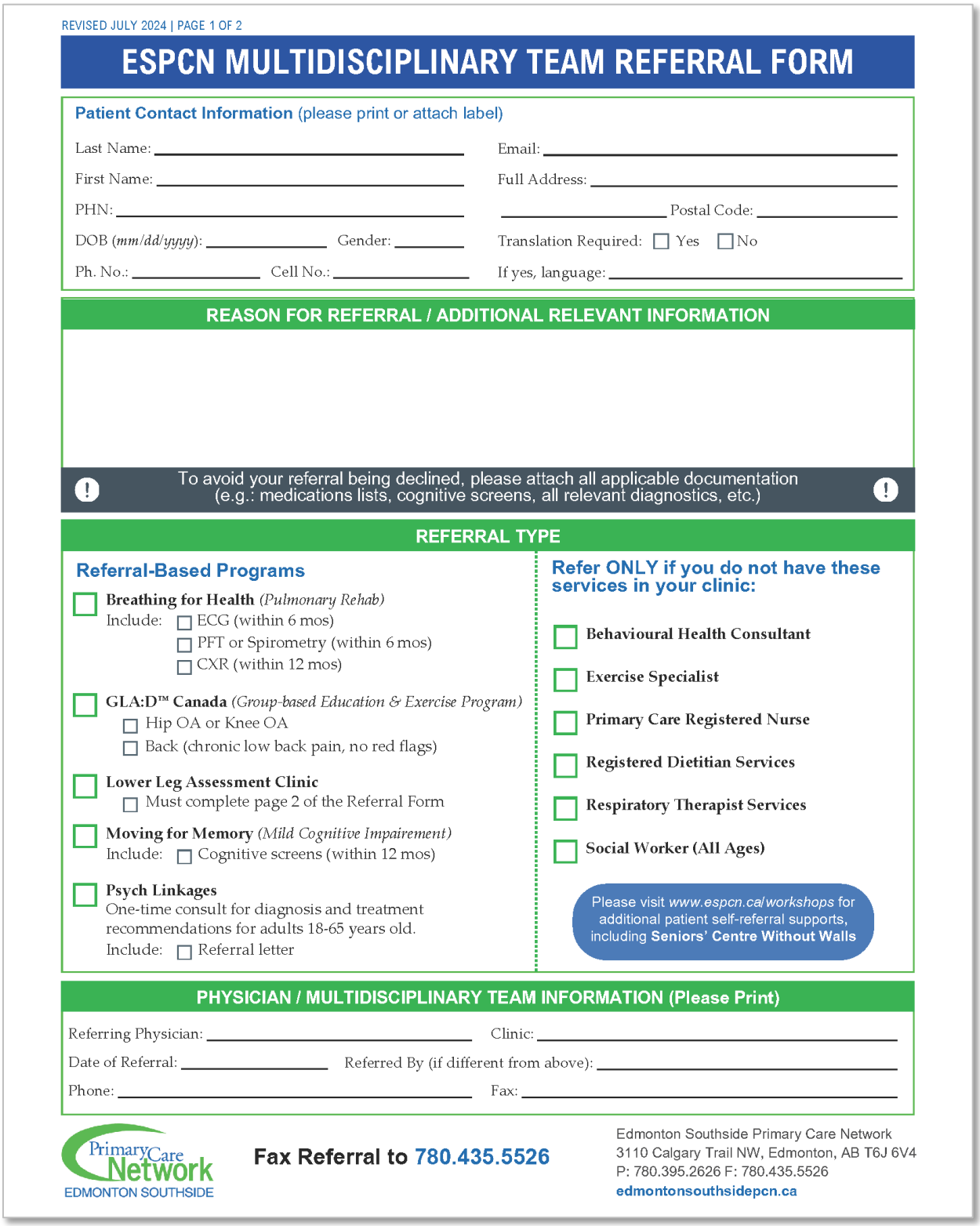
PCNs are governed by the following policy document created by Alberta Health. Revised in March 2018.

(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: ESPCN MDT Referral Form

https://www.edmontonsouthsidepcn.ca/app/uploads/Form-Central-Clinic-Referrals-July-2024.pdf



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ESPCN MULTIDISCIPLINARY TEAM REFERRAL FORM

Patient Contact Information (please print or attach label)

Last Name: _____ Email: _____

First Name: _____ Full Address: _____

PHN: _____ _____ Postal Code: _____

DOB (*mm/dd/yyyy*): _____ Gender: _____ Translation Required: ☐ Yes ☐ No

Ph. No.: _____ Cell No.: _____ If yes, language: _____

REASON FOR REFERRAL / ADDITIONAL RELEVANT INFORMATION

To avoid your referral being declined, please attach all applicable documentation (e.g.: medications lists, cognitive screens, all relevant diagnostics, etc.)

REFERRAL TYPE

Referral-Based Programs

☐ **Breathing for Health** *(Pulmonary Rehab)*
Include: ☐ ECG (within 6 mos) ☐ PFT or Spirometry (within 6 mos) ☐ CXR (within 12 mos)

☐ **GLA:D™ Canada** *(Group-based Education & Exercise Program)*
☐ Hip OA or Knee OA ☐ Back (chronic low back pain, no red flags)

☐ **Lower Leg Assessment Clinic**
☐ Must complete page 2 of the Referral Form

☐ **Moving for Memory** *(Mild Cognitive Impairement)*
Include: ☐ Cognitive screens (within 12 mos)

☐ **Psych Linkages**
One-time consult for diagnosis and treatment recommendations for adults 18-65 years old.
Include: ☐ Referral letter

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

☐ **Behavioural Health Consultant**

☐ **Exercise Specialist**

☐ **Primary Care Registered Nurse**

☐ **Registered Dietitian Services**

☐ **Respiratory Therapist Services**

☐ **Social Worker (All Ages)**

Please visit *www.espcn.ca/workshops* for additional patient self-referral supports, including **Seniors' Centre Without Walls**

PHYSICIAN / MULTIDISCIPLINARY TEAM INFORMATION (Please Print)

Referring Physician: _____ Clinic: _____

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

Phone: _____ Fax: _____

Primary Care Network EDMONTON SOUTHSIDE

Fax Referral to 780.435.5526

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

ESPCN LOWER LEG ASSESSMENT CLINIC REFERRAL FORM

Patient Contact Information (please print or attach label)

Name: _____

PHN: _____

DOB: _____ Gender: _____

Patient currently receiving Homecare services: ☐ Yes ☐ No

EXCLUSION CRITERIA:

1. **Homebound patients receiving Homecare services**
   (Please refer back to Homecare for lower leg edema or wound management)
2. **Patients who cannot transfer independently or lie flat for assessment**

PATIENTS MUST COMPLETE THE FOLLOWING TESTS PRIOR TO BEING SEEN AT THE CLINIC

☐ **ALL PATIENTS**: ABI **with toe pressures** (within 1 year)

☐ **WOUNDS only** (within 2 weeks of referral): CBC & diff, CRP, wound swab

THE FOLLOWING MUST ACCOMPANY THE REFERRAL

PATIENT MEDICAL HISTORY

☐ EMR summary that includes:

- ☐ Past Medical History

CURRENT MEDICATION (Please Attach List)

☐ All current medications

REASON FOR REFERRAL

☐ HIGH RISK FOOT

Please specify:

- ☐ Callus/pressure area
- ☐ Foot deformity

☐ LOWER LEG EDEMA

Currently wears compression stockings:

☐ Yes ☐ No

☐ WOUNDS

Wound location: _____

Has patient been treated at a wound clinic?

☐ No ☐ Yes, where: _____

ADDITIONAL INFORMATION

Primary Care Network
EDMONTON SOUTHSIDE

Fax Referral to 780.435.5526

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

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 patient's homes and are often carried out independently and leverage the use of medical directives and protocols to promote independent, autonomous practice. The PCRN role may vary based on panel and population needs. PCRNs also participate in quality improvement in the clinical 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 the 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, who 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. BHC services aim 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 and 6 appointments per concern. Patients are asked about physical symptoms, emotional concerns, behaviours, and how these might be related to one another.
- The BHC will complete a solution-focused functional assessment and assist in developing a behavioural 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 patient's 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 behavioural 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 the 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[31] supports the benefits of physical activity for the prevention and management of a variety of health conditions including but not limited to the following conditions:

- Circulatory: hypertension, coronary artery disease, peripheral vascular disease, congestive heart failure
- Pulmonary: asthma, COPD
- Musculoskeletal: arthritis/osteoarthritis, fibromyalgia, osteopenia/osteoporosis, sarcopenia, low back pain syndrome
- Neuromuscular: stroke, multiple sclerosis, spinal cord disability
- Endocrine & metabolic: dyslipidemia, diabetes, obesity, hypothyroidism
- 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.

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

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 the use of inhalers and adjunct therapy. They perform in-office pre and post-bronchodilator spirometry 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, counselling 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.

RTs 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 there 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 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 support 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 65 years 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 (including filling out application forms for certain benefits).
- Family violence support, including support for elder abuse.

What is the Referral Process?

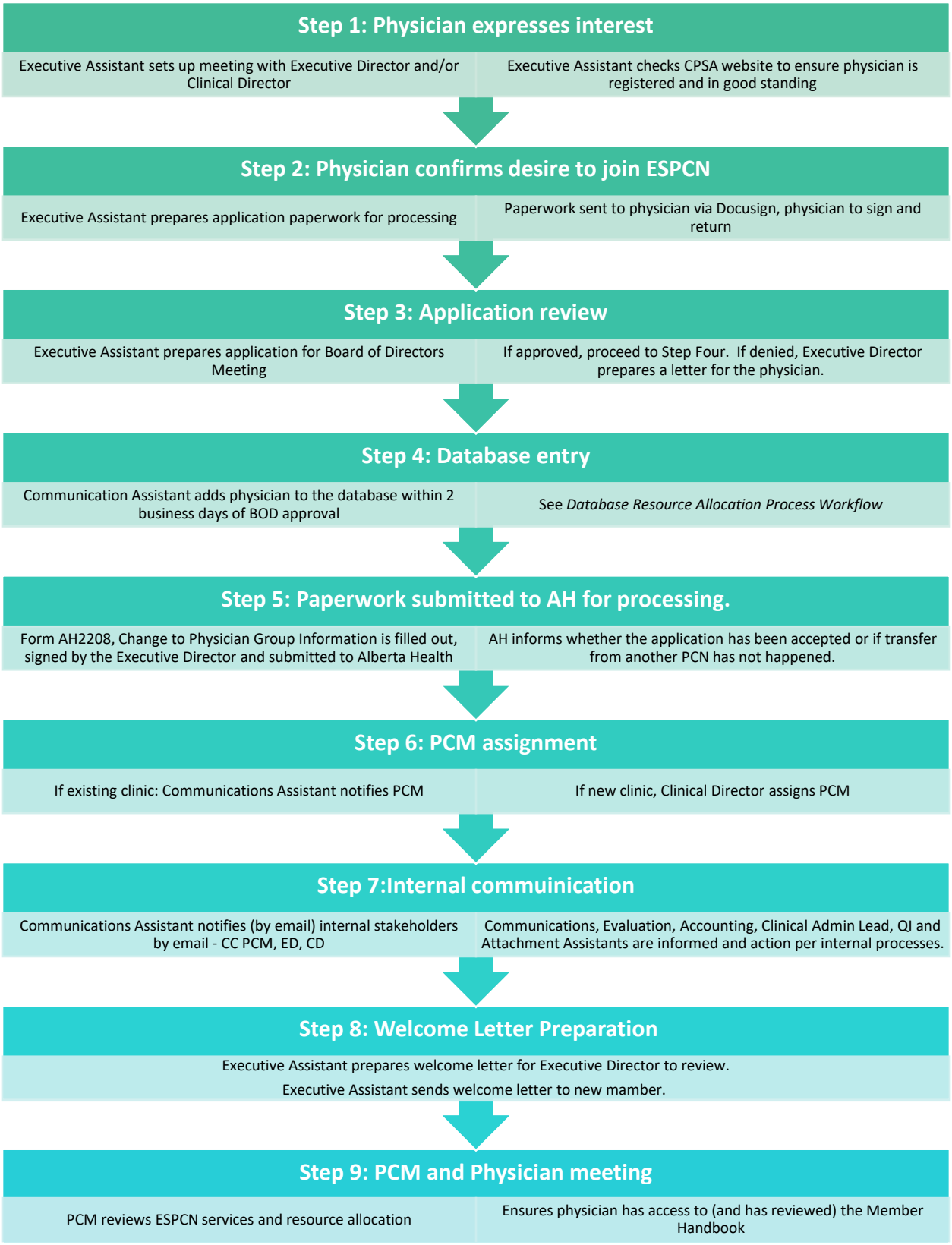
ESPCN physicians and MDT members can refer to the CSW or the HASW on the central referral form.

Appendix G: Schedule B - Primary Health Care Indicator Set

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

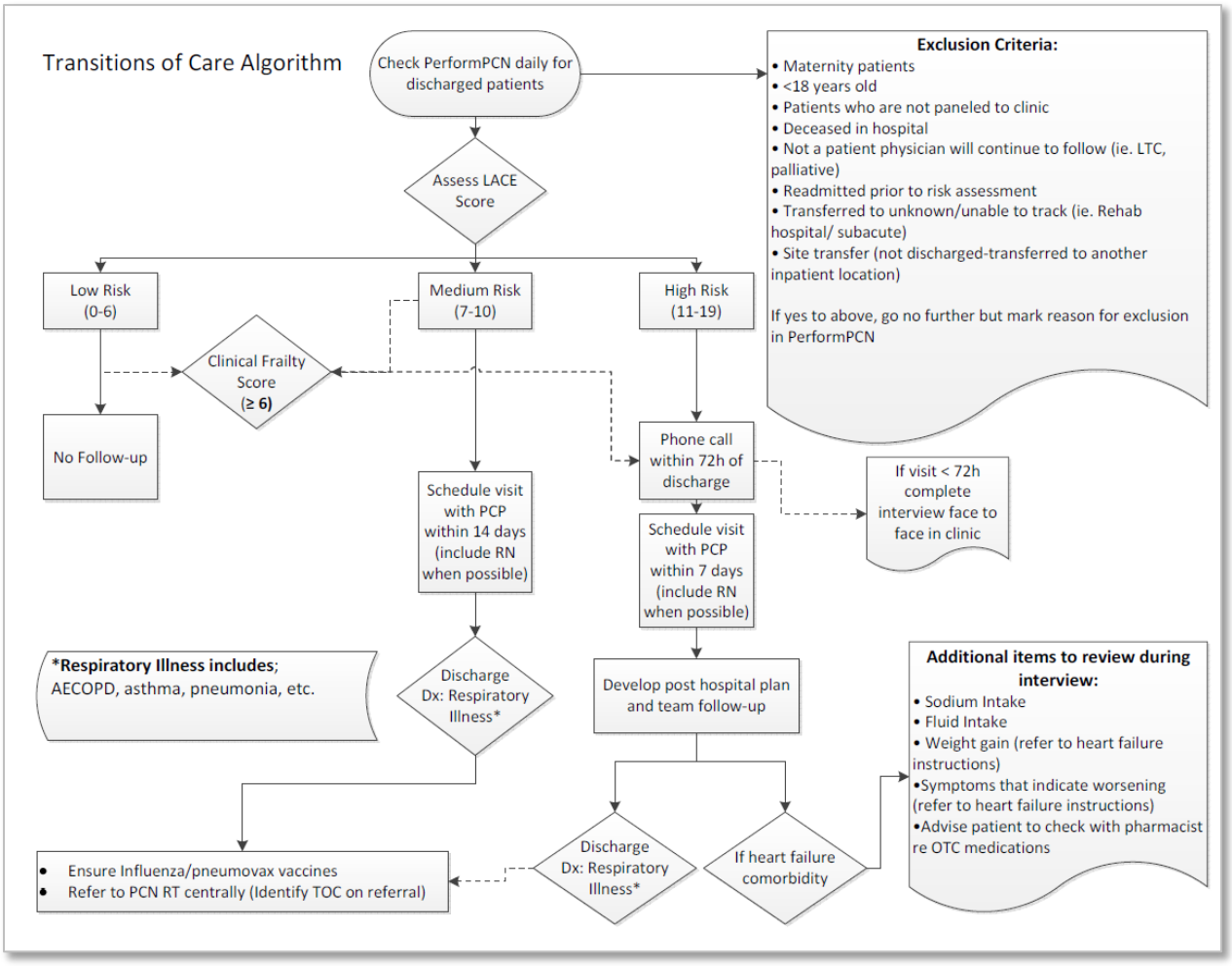
Third Next Available Appointment Indicator	Percentage of participating physicians in the PCN who are measuring the Time to Third Next Available Appointment (patient access measure)
Screening Indicator	Compliance with screening as recommended by the Alberta Screening and Prevention Initiative (ASaP)
Patient 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 the adoption of CII-CPAR a) How many medical clinics do the Participating Physicians/Providers work in? b) How many Participating Physicians/Providers are registered to your PCN? c) How many Participating Physicians/Providers are using a CII-CPAR compatible EMR? d) How many Participating Physicians/Providers have a Privacy Impact Assessment that is up-to-date and reflects the current environment? e) How many Participating Physicians/Providers routinely verify their Panels? f) How many Participating Physicians/Providers routinely verify their Panels by verification method? g) How many Participating Physicians/Providers are routinely submitting verified Panel information to CII-CPAR? h) How many Participating Physicians/Providers are routinely submitting verified Panel information to CII-CPAR and resolving conflicts? i) How many Participating Physicians/Providers utilize Panel information for proactive patient management?
Governance Indicator	Completion of PCN governance-related collective self-assessment and performance improvement plan, as required in the PCN program policies
Leadership Indicator	Assessment of the performance of the PCN Administrative Lead and all other staff members directly reporting to the PCN governance body (per the Joint Venture Agreement), as required in the PCN program policies

Appendix H: New Physician Flowchart



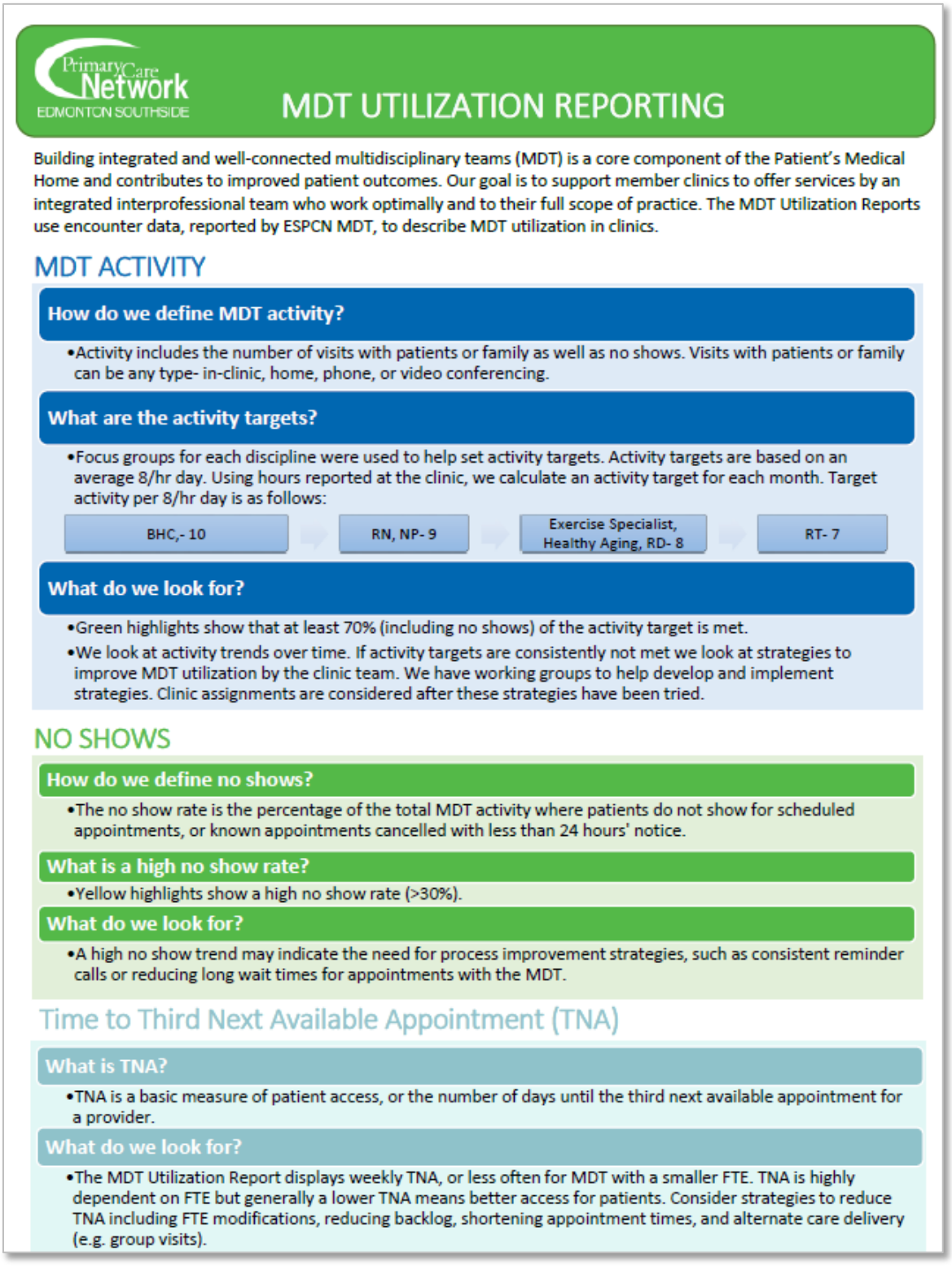
Appendix I: Transitions of Care Flow Chart

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



Appendix J: MDT Utilization Reporting

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



Primary Care Network
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/APPEDNIX-K-Clinic-Safety-Checklist.pdf

Edmonton Southside Primary Care Network

CLINIC SAFETY CHECKLIST

Updated November 2023

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? How many, where are they located and what is the expiry date? *Notes:*	◯ Yes	◯ No
Emergency Kit	Does the clinic have an Emergency Kit?	◯ Yes	◯ No

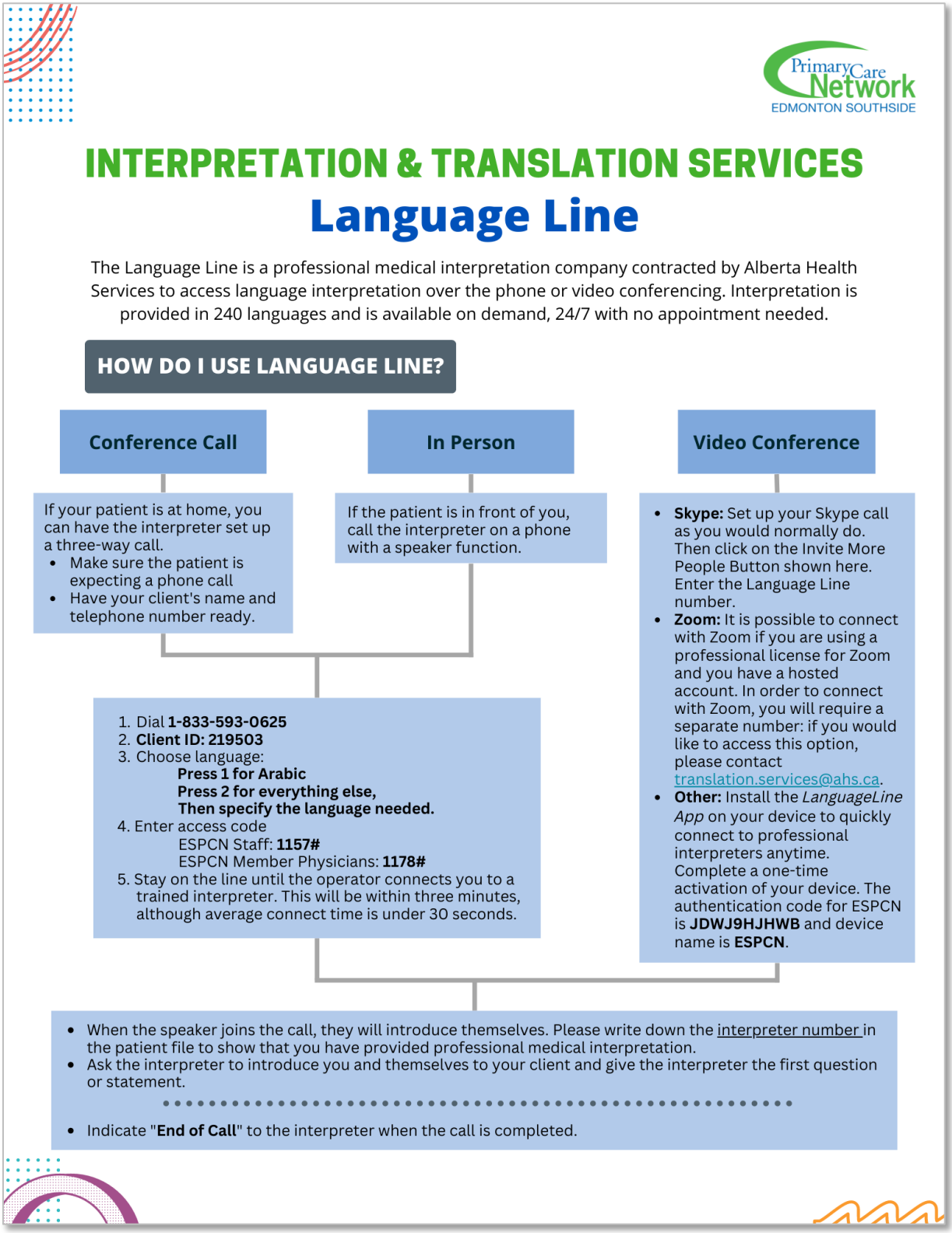
Edmonton Southside Primary Care Network

CLINIC SAFETY CHECKLIST

Emergency Medical Supplies	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 ◯ Yes	◯ No ◯ 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:*	◯ Yes	◯ No

Appendix L: ESPCN Language Line Interpretation Services

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



Appendix M: Central RD Triage Flow Chart

https://www.edmontonsouthsidepcn.ca/app/uploads/Central-RD-Triage-Flow-Chart-Updated-June-2024-1.pdf

Appendix N: Physician Membership Policy

https://www.edmontonsouthsidepcn.ca/app/uploads/APPENDIX-N-PCN-Policy-Physician-Membership-2023.pdf

POLICIES AND PROCEDURES

Approval Level: Management **Approved by: Board Chair**

Physician Membership

Purpose

This policy describes the process by which the ESPCN will proactively review and consider physicians who wish to join the ESPCN, the acceptance criteria for prospective physicians, and the responsibilities and expectations of participating physicians.

The ESPCN is committed to supporting participating physicians with clinical resources including providing skilled and dedicated multidisciplinary staff to work in their clinics. The ESPCN is committed to ensuring all patients have access to all services provided by the ESPCN.

This policy will contribute to the ESPCN's ability to manage its operations and successfully deliver its approved programming to participating physicians within the limitations of the funding model and the business plan then in effect.

Scope

This policy shall be applied to all physicians not currently members of the ESPCN, who have expressed an interest in joining and are prepared to work with the ESPCN to become participating physicians, and all participating physicians.

Definitions (if applicable)

Prospective physician – A physician interested in joining the ESPCN and who has expressed a willingness to work with the ESPCN to become a participating physician.

Participating physician – A physician who, or whose professional corporation, has signed a Letter of Participation that has been accepted by 1157178 Alberta Ltd.; and who has not either withdrawn or been terminated as a participating physician.

1. Acceptance Criteria for Prospective Physicians

1.1 All prospective physicians in a clinic must commit to the application process.

1.2 Prospective physicians must express a willingness and commitment to:

a. Alignment with the principles and pillars of the Patient's Medical Home, which will include team-based care, patient-centred focus, capacity for improvement and continuity.

Last Reviewed Date: August 14, 2023 Page 1 of 4
Next Review Date: August 14, 2024

b. Modify their practice behaviours and habits, as reasonably required to facilitate enhanced multidisciplinary team-based care.

1.3 Prospective physicians must be located in Alberta, practice in the Edmonton area and be able to participate in a team-based care approach, in partnership with ESPCN multi-disciplinary team. Clinic location and proximity to the ESPCN can be considered in membership decisions.

1.4 Prospective physicians:

a. Direct the clinic's administrative and non-clinical staff to support and provide administrative assistance to on-site ESPCN employees/contractors, which may include multidisciplinary team members, quality improvement team members, or PCN management.
b. Provide reasonable infrastructure and overhead support, equipment, and materials, unless otherwise specified, to on-site ESPCN employees/contractors.
c. Inform the ESPCN immediately of any physicians that have left the practice and/or new physicians that join the clinic.
d. Inform the ESPCN immediately of significant changes to the clinic environment that may affect PCN staff, such as hours of operation, geographic location, facility improvements, etc. This obligation shall apply both during the assessment process and on an ongoing basis after approval if the Prospective Physician becomes a Participating Physician.

1.5 Prospective physicians must indicate their willingness to apply their best efforts to fulfill the objectives of the Business Plan by signing the following documents.

a. Business Plan, then in effect;
b. Letter of Participation;
c. ESPCN Application Form;
d. Physician Consent (Alberta Health document AH2201)

1.6 The PCN has the right to change the required documents listed in 1.5 at any time.

1.7 For prospective physicians who have either withdrawn or been terminated from the ESPCN, all factors at the time of the previous decision will be considered in determination of membership, at the discretion of the Board of Directors.

1.8 Completed physician applications and documentation must be returned to the ESPCN no later than February 15 or August 15 to be included in Alberta Health's semi-annual enrollment updates on April 1 or October 1, respectively.

2. *Addition of New Physicians to the PCN*

2.1 The PCN will formally increase the number of participating physicians (and corresponding PCN support) for new co-located support on April 1 and October 1 only, aligned with the panel information provided by Alberta Health.

2.2 Prospective physicians' applications will be reviewed by management for completeness.

2.3 Prospective physicians' applications must be approved by the Board of Directors.

3. *Participating Physicians*

3.1 Participating physicians must inform the PCN of practice location changes in order for the PCN to effectively support them and their patients.

3.2 Panel can be allocated to more than one clinic based on the time a physician practices at clinic based on the time a physician practices at clinic locations. These panel splits can be made in 20 or 50% increments only.

a. How a physician's panel is split between clinics or practice locations can only be changed on an annual basis in September. The physician must notify the PCN of changes to panel splits by September 30th each year.

3.3 Participating physicians must allocate adequate and dedicated space for use by ESPCN professionals and others (i.e. psychiatrists) in the course of their work in delivering patient care at the clinic. Hallway counters, shared exam rooms, or other shared workspaces are not acceptable and MDT support will not be made available.

3.4 Prospective physicians must provide assurance that the clinic owner(s), if other than the prospective physician(s) is/are amenable to physician membership in the ESPCN and is/are prepared to support the participating physicians relationship with the ESPCN including permitting ESPCN employees/contractors to access to the clinic site.

3.5 Participating physicians must be located in Alberta, practice in the Edmonton area and be able to participate in a team based care approach, in partnership with the ESPCN multi-disciplinary team.

3.6 Participating physicians must be a member in good standing with the College of Physicians and Surgeons of Alberta (CPSA).

3.7 Practice restrictions, limitations or conditions imposed by the CPSA or any other authority, harassment of ESPCN staff, and/or criminal convictions may result in revoking a physician's membership. The ESCPN and participating physicians will agree in advance what is appropriate for the ESPCN's multidisciplinary teams use, which may be different for each clinic, based on the number and type of ESPCN professionals,

available space at the clinic, potential for renovation at the clinic, and physician schedules.

3.8 As a minimum, the participating physicians must allocate administrative (i.e. office or workstation) and clinical space (i.e. exam room) suitable for use by PCN professionals that are assigned to the clinic on a part- or full-time basis (i.e. nurses, social workers, dieticians, psychiatrists). This must not be a shared space with physicians or other multi-disciplinary team members, during the same work hours. Ideally, this space will be co-located with the participating physicians within the practice and facilitate collaborative patient care.

3.9 Participating physicians will support the development of a multi-disciplinary team, with each team member working to full scope of practice, within the member physician clinic.

4. Termination

4.1 The Board of Directors, may terminate the membership of any participating physician in accordance with Article 5.2 of the ESPCN's Articles of Association.

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