Primary Care Network
EDMONTON SOUTHSIDE

2022/2023 ANNUAL REPORT

OPTIMIZATION IN PRIMARY CARE

INTRODUCTION

Our annual report explores Edmonton Southside Primary Care Network's (ESPCN) achievements in supporting and caring for patients. This year's report illustrates the ways our PCN has utilized resources and optimized care and programming to support our patients in their health journeys. We are an organization that is, and has always been, comfortable with change and evaluating the differences we are making to the patient population.

ABOUT THE EDMONTON SOUTHSIDE PRIMARY CARE NETWORK

The Edmonton Southside Primary Care Network was the first primary care network in Alberta. Over the past 18 years, the ESPCN has grown to become the largest PCN in Edmonton and consists of a team of health care professionals who are passionate about creating healthier communities. Each member of our multidisciplinary team (MDT) plays a specific role in improving, coordinating, and delivering primary health services. Our team is composed of primary care registered nurses, nurse practitioners, behavioural health consultants, social workers, registered dietitians, exercise specialists, respiratory therapists, quality improvement and administrative staff.

Our priority is building strong Medical Homes to improve our patients' health and wellness. We provide services to patients dealing with complex and chronic health issues such as diabetes, mental health, and obesity. By incorporating a multidisciplinary team model that is co-located into medical homes, physicians can provide more holistic care to their patients.

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

CONTENTS

WHAT IS A PCN?

A Primary Care Network (PCN) is an organization that works within their community to bring together family doctors with a team of health care professionals to provide collaborative patient care. Each multidisciplinary team is unique to every PCN and the population that they serve. At the ESPCN, primary care registered nurses, nurse practitioners, behavioural health consultants, exercise specialists, dietitians, and respiratory therapists connect with family doctors and patients to assist with providing the right knowledge and resources to cover every care need.

WHAT IS THE EDMONTON SOUTHSIDE PCN?

The Edmonton Southside PCN connects our team of health care providers to the patients that need them, through the family doctor that cares for them. The PCN's role is to connect patients tospecialized support and services as needed. Our team approach integrates the valuable relationship between family physicians and their patients, with the broader services and larger philosophy of the PCN, to offer the greatest benefits to individuals, families, and the health system. Our highly trained multidisciplinary team is a valuable resource for physicians, helping to provide enhanced primary care at clinics and in the community, through programs and services. The almost 190 ESPCN staff work with over 330 family physicians at 100+ member clinics to offer compassionate comprehensive care to patients.

WHAT IS A MEDICAL HOME?

A Medical Home puts patients' needs at the centre of care. It emphasizes prevention through primary care and connection to broader health services when needed. Health care works best when it is delivered in a family practice that offers the necessary care for all stages of life, while enabling patients to work towards managing their own health. The ESPCN uses a team-centred approach, to encourage valuable relationships between family physicians and their patients through a wide range of services that best supports individuals, families, and their community.

VISION

The trusted cornerstone of a healthy community

MISSION

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

VALUES

Respect, Passion, Collaboration, Dedication, Innovation

MESSAGE FROM THE BOARD

Over the last year the ESPCN has focused on optimizing our programs and clinical offerings by continuously evaluating our services, making changes, and trialing new ideas to ensure patients receive the best care and education for their health concerns that we can provide. Despite this effort, access continues to be a problem for patients and providers. The healthcare landscape in Alberta is challenging in many ways. There is a great deal of pressure to see more patients, even as physician supply continues to decrease. The work of the ESPCN over the last year continues to help mitigate some of this pressure.

The funding model for Primary Care Networks in Alberta has remained unchanged since 2012. We've also been faced with new challenges—and we made some tough choices. Our strategy of capitalizing small gains and exploring ways to do more with the same has resulted in a year of finding opportunities: opportunities to expand partnerships, to optimize programming and delivery of care, and to create efficiencies wherever possible. We still strive to improve primary care in Alberta.

CELEBRATING SUCCESSES AND CREATING STABILITY

We have many successes to celebrate this year, including the Supported Therapy Pilot. Though it is still in its infancy, the Supported Therapy Pilot is a big win. Through this pilot, we provide access to mental health supports to patients who may not have the means to otherwise access these services. We will continue to evaluate this pilot to determine the long-term feasibility and impact of this program.

Other notable successes focused on creating more stability and efficiency in the current services we offer and the way we allocate resources to clinics.

> *Through this pilot, we provide access to mental health supports to patients who may not have the means to otherwise access these services.*

IMPROVING SERVICES AND FOCUSING ON BEST-PRACTICE

While we can't physically generate more doctors, continuing to improve our paneling process across practices enables physicians and clinics to identify their patient population. This is a great step towards ensuring that the patients attached to the ESPCN are receiving the right care at the right time. Physicians who go through the process of identifying their panels and do the work to address access are able to open their practices and see more patients. At the end of the day this is a success for the patient population that we serve.

The introduction of the proactive care coordination assistant role is a great example of making use of existing resources by shifting the focus of a role to optimize the outreach capability and improve access for patients who need it most. The previous panel management assistants focused predominantly on screening, but there's more to that role than screening. The real focus of this role is access and continuity, which is a key priority for the ESPCN Board.

BUILDING ON SUCCESSFUL PARTNERSHIPS

With the demand for family doctors at an all-time high, being able to catch up with today's work is a struggle for all physicians in Alberta. In an attempt to address these concerns, to advocate at a system level, and to foster collaboration within the zone, the Edmonton Southside PCN and Edmonton West PCN partnered to deliver a series of one-hour webinars for physicians to learn strategies to battle burnout. These webinars focused on improving clinical processes, the importance of medical learners to the future of primary care, and exploring different aspects of physician compensation.

With the leadership of our family physicians, the commitment of our staff and the support of our partners and stakeholders, ESPCN continues to make a difference. As an organization we strive to make a positive impact on the health system as a whole, on those who provide primary health services and, of course, on the population who relies on the services that we are able to provide.

Dr. Ron Shute
ESPCN Board Chair

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OUR BUSINESS PLAN PRIORITIES

Our Business Plan, which guides all our work identifies several key priorities, including **Clinical Supports and Services, Medical Neighbourhood**, **Medical Home Optimization** and **Community Development**.

CLINICAL SUPPORTS & SERVICES

Ensuring the multidisciplinary teams (MDT) reflect medical home pillars and alignment with the Medical Neighbourhood. This includes team-based care providing one-on-one appointments, group medical visits, group education, and MDT integrating into member clinics.

MEDICAL HOME OPTIMIZATION

Focusing on the expansion of quality improvement initiatives to better reflect Medical Home pillars and the inclusion of elements such as education and evaluation.

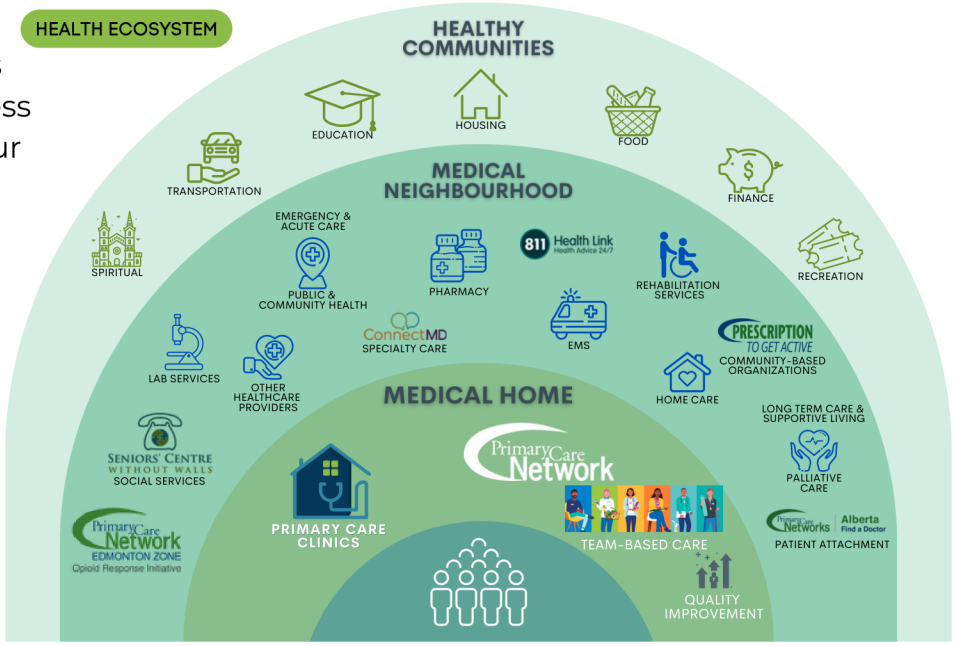
COMMUNITY DEVELOPMENT

Leveraging ESPCN's social and community supports that impact and benefit the overall well-being of our patients as an extension of the Medical Neighbourhood and Medical Home. This includes Seniors' Centre Without Walls and proactive development of community partnerships.

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 collaborates with these agencies to integrate and align care to improve the experience and results for the patient population.

Everything we do is guided by our Business Plan priorities and our commitment to patients and their medical homes!

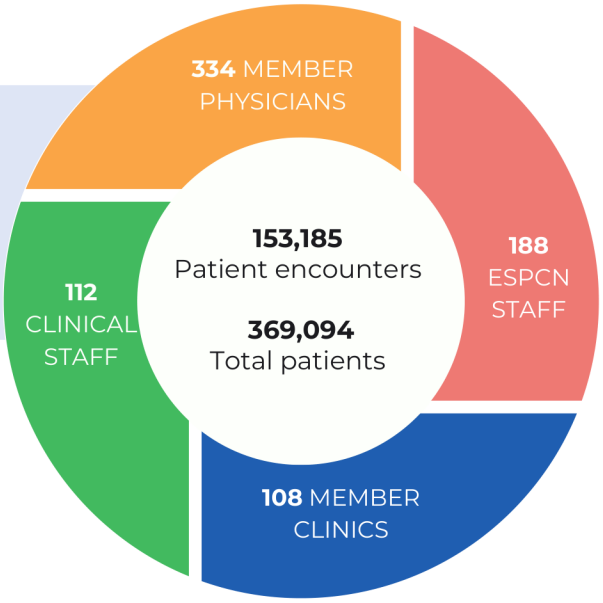


2022/2023 ESPCN STATS

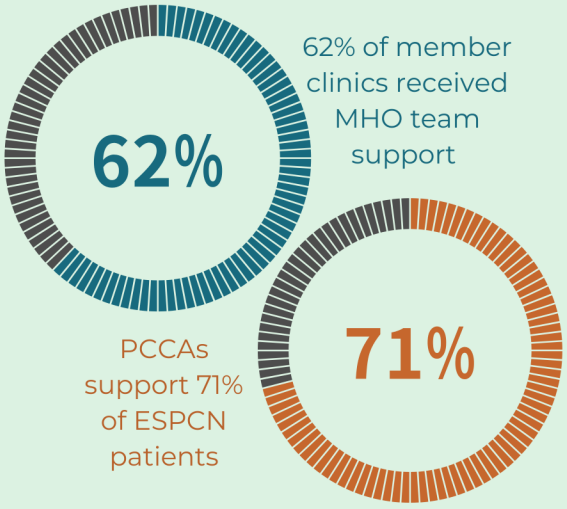
as of March 30, 2023

79%
Most member clinics have at least one integrated MDT

3,662 people
took part in PCN-led group classes



MEDICAL HOME SUPPORT



62% of member clinics received MHO team support

PCCAs support 71% of ESPCN patients

MANAGING COMPLEX PATIENTS

MDT reported **35,553 encounters** focused on managing complex patients, representing almost one-quarter (23%) of all MDT encounters

51.5%
of ESPCN clinics have continuous panelling processes

41.8%
of member clinics have ongoing processes to call patients not presenting within 3 years

GROWTH IN PANELING

The number of clinics conducting panel outreach continued to rise: from 20.8% in 2020/21 and 39.1% in 2021/22, to **47.2% in 2022/23**

SCWW held over **900 individual program sessions**, including between 125-150 active participants each quarter

SENIORS' CENTRE WITHOUT WALLS

CLINICAL SUPPORTS & SERVICES

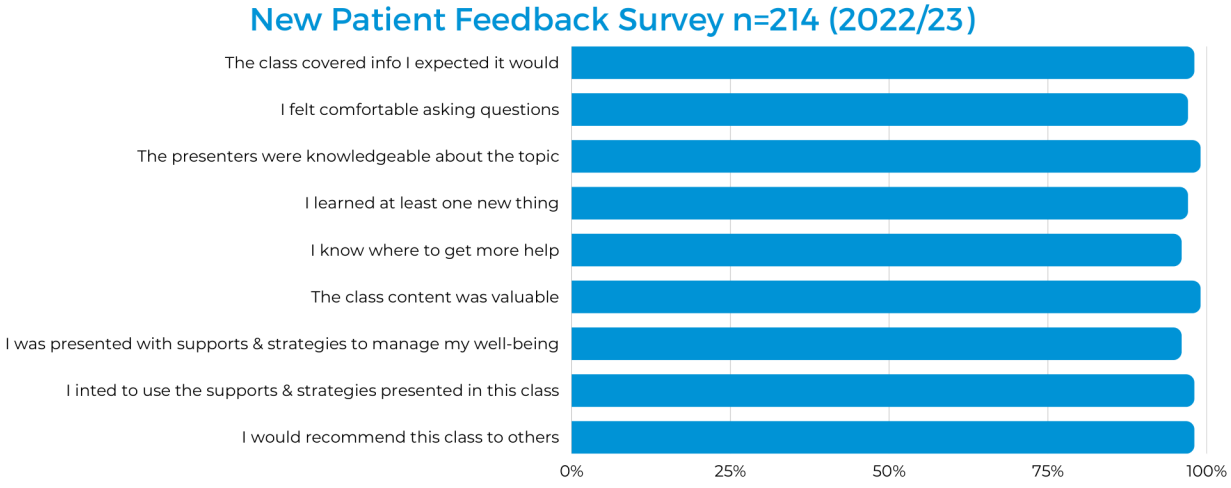
Our multidisciplinary team members (MDT) and group classes play an important role in the health of our patients by enhancing the care a patient receives from their family physician. As a mostly de-centralized organization, we work to continuously monitor and improve the scope of practice of our clinicians in member practices – this means finding ways to be more efficient with resources and respond to the needs of the patient population. The ESPCN continues to optimize our programming and clinical offerings by continuously evaluating our services, making changes, and trialing programs to ensure patients receive the best care and education for their health concerns that we can provide.

GROUPS & WORKSHOPS

In 2022/23 the Edmonton Southside PCN offered 18 different workshops to help patients and families meet their health and wellness goals. Workshops offered by the ESPCN help patients stay healthy, access the care they need and learn how to make the most of their ongoing relationship with their health care team.

Over this past year, we shifted nine workshops back to in-person delivery. At the end of each workshop, participants are invited to complete an online survey. Responses to these surveys were highly rated with 99% of respondents indicating that the class content was valuable and 98% indicating that they intend to use the supports and strategies presented.

We had 3,662 people take part in PCN-led workshops this year, which is up from 3,017 in 2022. Workshop topics include mental health, nutrition, exercise, healthy aging, lung health and pregnancy.



MULTIDISCIPLINARY TEAMS

Multidisciplinary teams (MDT), in partnership with member physicians, focus on complex populations such as patients living with multiple chronic health conditions, seniors, and those with psychosocial difficulties.

Primary Care Registered Nurses (PCRN) provide comprehensive nursing services and care to patients in primary care. PCRNs provide holistic, patient-centred care across the lifespan with a goal of improving health outcomes and facilitating access to services.

Nurse Practitioners (NP) are health professionals with a master's degree in nursing who can provide essential health care services in the medical home. 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.

Behavioural Health Consultants (BHC) address chronic disease and mental health concerns through evidence-based behavioural interventions. BHCs work with patients on their physical, behavioural and emotional concerns and help 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.

Registered Dietitians (RD) are uniquely trained to advise on food and nutrition for overall health and wellness and work collaboratively with physicians and the multidisciplinary team. RDs provide nutrition counselling using motivational interviewing, problem solving and cognitive behavioral strategies. They are qualified to provide medical nutrition therapy for the prevention, delay and management of disease.

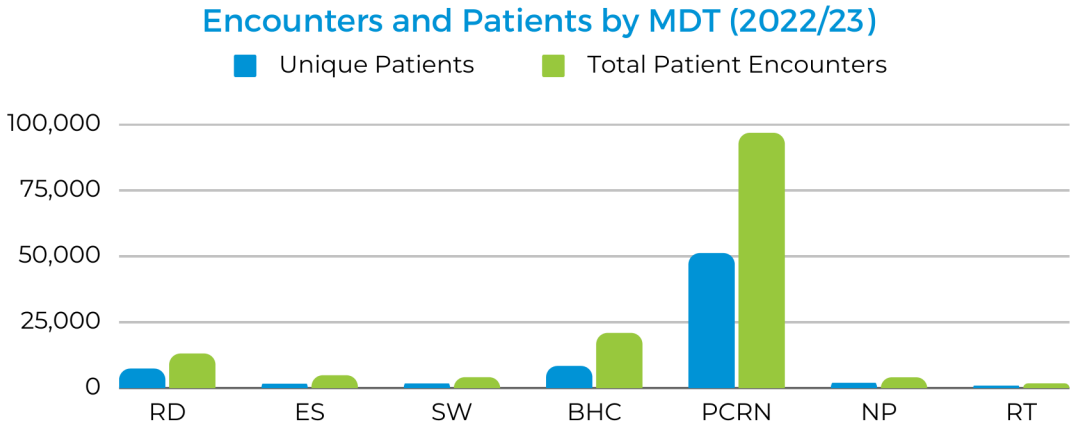
Exercise Specialists (ES) promote and prescribe physical activity to prevent and manage chronic health issues. Exercise specialists hold at a minimum a bachelor's degree in physical education or kinesiology. They also hold the designation of Clinical Exercise Physiologist™ (CEP) through the Canadian Society for Exercise Physiology (CSEP).

Respiratory Therapists (RT) assess, monitor, and help to help people manage living with a respiratory disease. The role of RTs is to participate in the planning, implementation, and evaluation of respiratory care plans. RTs provide education and disease management strategies for any respiratory disease, counseling on smoking cessation, review of respiratory medication with a demonstration of proper inhaler device techniques, and development of action plans.

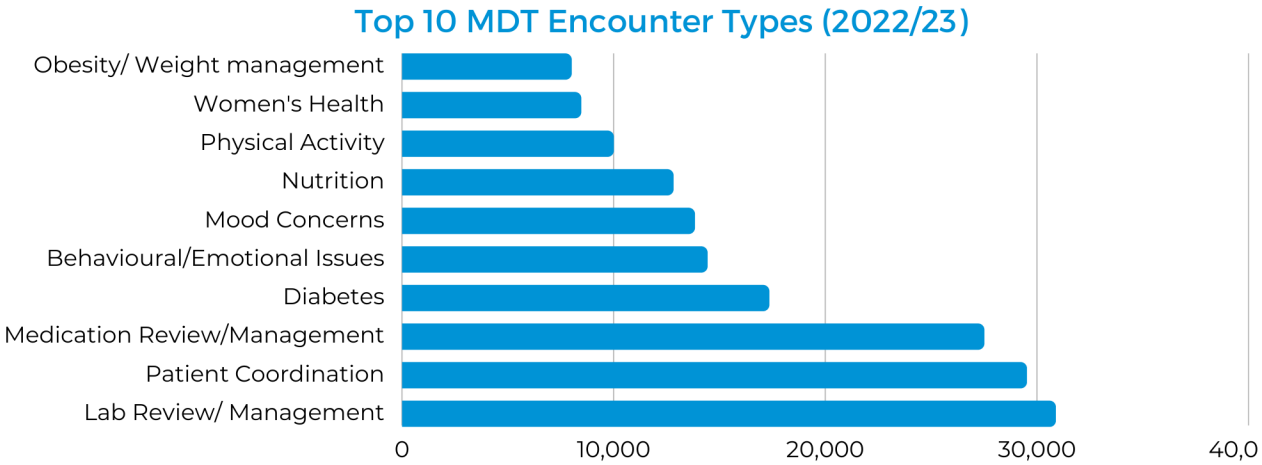
Social Workers (SW) support patients of all ages to identify and access appropriate services, through collaboration with other professionals within the multidisciplinary team. Social workers engage people and communities to address life and build resiliency by providing practical supports related to the social determinants of health.

Most member clinics (79%) have at least one integrated MDT in 2022/23, which is consistent with previous years. One significant advantage of co-location is the large volume of encounters (153,185) and patients (68,494) served by ESPCN MDT.

MULTIDISCIPLINARY TEAM ENCOUNTERS



The following are the top reasons for encounters in 2022/23 with a member or members of the MDT and top encounter types by discipline.



A patient's medical home serves as the hub for coordination and care continuity for health care services that patients receive throughout the health care community. ESPCN MDT play a key role in supporting our family physicians to coordinate care for complex patients. Our MDT often function as system navigators and patient coordinators. Strong care coordination is an essential component of effective health services that promote health and well-being.

In 2022/23, MDT reported 35,553 encounters focused on managing complex patients, representing 23% of all MDT encounters. One-third of patients were supported with care coordination.

RESOURCE ALLOCATION CHANGES

In the spring of 2022, the ESPCN took on a new approach to resource allocation – meaning the assignment of clinical staff to physician member clinics (aka medical homes).

Historically, the PCN had to react to small shifts in available funding due to small increases or decreases in physician membership or patient panels. With small numbers of staff shifted or moved to our member clinics according to these small shifts in available resources, this approach focused more on budget constraints and less on the needs of our patient population. This previous approach also led to very small assignments for some clinical staff, less than one day per week in some cases, which is onerous on the clinic, managers and the staff, and patients. A new resource allocation approach was implemented April 1, 2022, which meant assigning ESPCN clinical support to member clinics based on specific bands of 800 patients per band (panel information is supplied by Alberta Health).

With the roll-out of this new resource allocation approach, the ESPCN saw increased stability in clinic MDT supports, the number of staffing shifts in fall 2022 (43) requiring significantly less shifts than spring 2022 (135).

This shift brought about positive changes for the PCN and member clinics. The elimination of the micro-assignments means that resources and support are available through the central ESPCN clinic for smaller clinics. This change provides a greater opportunity for improved access to patients through the PCN. Further, it also leads to fewer staffing changes for clinics, which improves patient-provider continuity.

HIGHLIGHT OF CLINICAL SUPPORTS & SERVICES ACCOMPLISHMENTS

LOWER LEG ASSESSMENT CLINIC

The Lower Leg Assessment Clininc (LLAC) clinic opened in January 2020, expanding our previous High Risk Foot Program. This expansion includes a comprehensive approach to lower leg and foot assessments including wound management, lower leg edema, and high-risk foot conditions. In 2022/23, the LLAC operated four days per week, Tuesday through Friday.

In 2022/23, this clinic consisted of one Canadian-certified RN who specializes in wound, ostomy and continence, and oversees daily assessment, care, and coordination of patients referred to the program. The clinic also has an Occupational Therapist who available two Fridays per month and provides collaborative care with the RN for high-risk foot patients. The ESPCN will be increasing clinic capacity in 2023/24 by adding an additional RN, trained in wounds and edema management, which will enable the clinic to be open five days per week.

The LLAC RN provides care to patients for edema assessment and management, including Alberta Aid to Daily Living (AADL) authorization of stockings for those meeting the criteria. The RN also provides care and treatment for patients with chronic and acute wounds, including sharp debridement which requires specialized training. This treatment improves healing for patients that are at high risk for infections.

In 2022/23, the LLAC received an average of 36 referrals each month. In a study of patient outcomes one-year post-program, 350+ patients with first their LLAC appointment between September 22, 2020, and December 22, 2022, had low one-year amputation rates (1.09% overall, 2.88% high risk foot). Preliminary analysis also shows a 43% reduction in yearly lower leg related emergency department visits, a 6% reduction in overall emergency department visits, and a 2% reduction in claims. While hospitalizations increased 41% overall, lower leg-related admissions increased only 14%.

CENTRAL SOCIAL WORKER - Focus on social determinants of health

In 2020, the ESPCN introduced the central social worker role to support patients of all ages in addressing barriers related to the social determinants of health. At an organizational level, ESPCN has been working towards introducing further clarity to the social worker role in primary care and enhancing the scope of practice with our member physicians. Two social workers now support patients at the ESPCN central office. They assist patients and families who require support in accessing financial, housing, employment, and health services. Assistance with personal directives, enduring power of attorney documents and capacity assessments for guardianship or trusteeship is also available. In the last year, we received 1,013 referrals to the central social workers.

TRANSITIONS OF CARE

The ESPCN continues to deliver our Transitions of Care program to connect high-risk patients who have recently been discharged from hospital to primary care RNs and their clinic teams. This program is an embedded process for ESPCN clinics. This initiative successfully supports nursing involvement with complex patients, assists primary care teams to focus on patients with highest risk for adverse outcomes, and reduces admissions to hospital and emergency departments when receiving the seven-day primary care follow-up offered through this program.

Between July and December 2022, the ESPCN monitored 7,037 hospital discharges with 26% of these patients identified as high-risk. Three-quarters of these high-risk patients received primary care follow up within the target seven days following hospital discharge, while 98% of medium risk patients had follow-up arranged for 14 days post-discharge. 525 high-risk patients received a post-hospital phone call by the primary care RN within their patients' medical home.

Outcome data shows that ESPCN high-risk patients who received the recommended primary care seven-day follow-up had fewer 30-day emergency department revisits (25% seven-day follow-up; 36% no follow-up) and fewer 30-day readmissions (15% seven-day follow-up; 26% no follow-up) than patients without follow up. Avoidable emergency department visit rates for ESPCN were below provincial and zonal levels (5% ESPCN; 10-12% Edmonton Zone - family practice sensitive conditions) indicating ESPCN patients are not commonly going to the Emergency Department for reasons that should be dealt with in the patient medical home.

RESPIRATORY THERAPY AND THE COPD & ASTHMA CLINIC

The change to our approach to resource allocation led to the respiratory therapy team becoming more centralized at the ESPCN office in 2022/23. There is now a respiratory therapist on site at the central office each day of the week, which has improved access for patients. This year, the respiratory therapists met with 924 unique patients, an increase of 23% over last year.

Recognizing the need to enhance preventative care, the RT team developed a proposal for a COPD & Asthma Clinic. The COPD & Asthma Clinic enables the RT team to provide comprehensive, evidence informed care for patients ages 6 and up. Patients have lifetime access to the COPD & Asthma Clinic, including referrals to a lung specialist as required. The clinic also provides an objective measurement of lung function (spirometry testing), self-management education and action plans to prevent disease flare-ups and reduce acute care visits.

The COPD & Asthma clinic opened in March of 2023. In the first month, 20 patients with asthma and 19 patients with COPD were enrolled in the program. The RT team also saw the return of the Breathing for Health pulmonary rehabilitation program in-person in 2022/23. Two groups were successfully completed with a total of 18 participants.

SUPPORTED THERAPY PILOT - Increasing Access to Counseling Services

In the 2021 Annual Member Survey, ESPCN member physicians identified a need for “increased trauma-informed psychology, mental health counselling, and direct psychiatric counselling”. In response to this feedback, along with identified patient need, the Supported Therapy Pilot was launched in February 2023.

The Supported Therapy Pilot provides a patient with up to six fully subsidized counselling sessions with a registered psychologist or a registered provisional psychologist, in partnership with Cornerstone Counselling. There are three main eligibility criteria for access to the pilot:

(1) household income equal to or less than $100K,
(2) no access to non-insured health benefits covering psychological services, and
(3) demonstrated motivation and readiness for counselling, as assessed by a BHC.

From February to March 2023, ESPCN BHCs conducted 184 assessments to refer patients to the Supported Therapy Pilot. Of these assessments, 92 referrals were sent to Cornerstone Counselling. This pilot program will run until the end of March 2024. Evaluation is currently underway to determine the long-term feasibility and impact of the program.

MEDICAL HOME OPTIMIZATION

Within the Medical Home Optimization priority initiative, change management resources are provided to member physicians and clinics to support optimization of the patients' medical home (PMH). Each PMH strives for progress through performance measurement and continuous quality improvement. This includes establishing and evaluating the quality of services provided to patients and using results to enhance operations. Practices, and the physicians within each practice, are at various states of PMH transformation and readiness for change. The ESPCN responds to this range among member practices by applying common principles while supporting quality improvement activities identified as meaningful for member physicians and their teams.

The relationship between patients, physicians and the health care team is a vital component of the PMH. The Quality Improvement (QI) team at the ESPCN is focused on medical home optimization in our PCN member clinics. Medical home optimization leads to improved access, increased services, and ultimately better outcomes for all patients. With the introduction of the proactive care coordination assistant (PCCA) role in 2022, the PCN was able to convert the existing panel management assistant role to focus on increased patient outreach and appropriate screening and ensure that more patients receive the right care to meet their health needs.

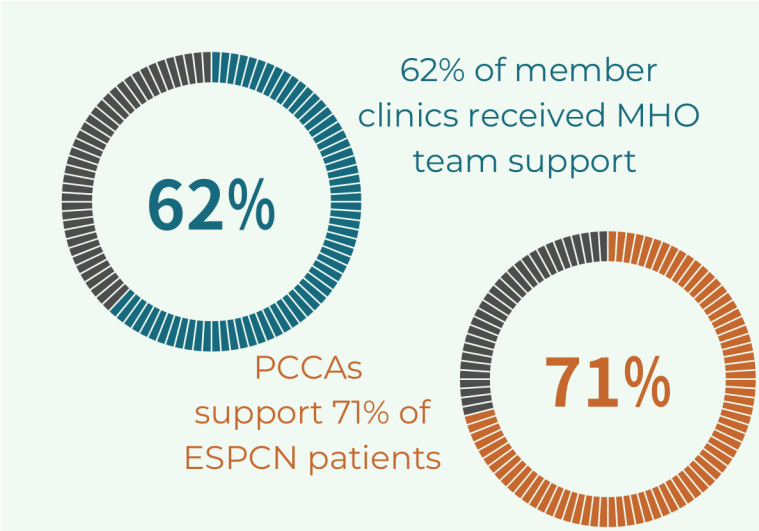
SHIFT TO PROACTIVE CARE COORDINATION ASSISTANTS

In November 2022, a new position was introduced on the Quality Improvement team, replacing the former panel management assistant role: proactive care coordination assistant. 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 improvement facilitator (IF). The Proactive Care Coordination (PCC) program serves as a safety net to prevent vulnerable patients from falling through the cracks in our health system. The PCCA role within a clinic is foundational to supporting a clinic's journey towards being a Patient's Medical Home.

This position is entirely outreach focused: PCCAs use evidence-based guidelines to book follow-up for patients who have not seen their primary care provider (PCP) in over 3 years, who are elderly or have a chronic disease and have not seen their PCP in over one year, or who are due for preventative screening.

HEALTH TRANSFORMATION WORKFORCE

ESPCN supports clinic teams through investment in our health transformation workforce including improvement facilitators, EMR consultants and proactive care coordination assistants. The expansion of the PCCA model in 2022/23 included an additional 5 FTE, with shifts allowing support in an additional eight member clinics. A new PCC lead was introduced to streamline the reporting structure of PCCAs and allow for better support and oversight.



QUALITY IMPROVEMENT STAFF SUMMARY (2022/23)

62% of member clinics received MHO team support in the last year. The number of clinics meeting regularly as a QI team increased slightly- from 25.5% to 28.7%. The ESPCN developed an annual QI plan template and supports physicians to complete and implement these plans.

ROLE	FOCUS
QI Manager	Strategic oversight and management of MHO/ Quality Improvement program.
Improvement Facilitator	Facilitate quality improvement meetings, support clinic teams to set goals, and assist in measurement, spread and scale of improvement efforts.
EMR Consultant	Support clinic teams to optimize their EMRs by building queries, templates, automated notifications, and assist with staff training.
PCC Lead	Supports PCCA direct reports.
Proactive Care Coordination Assistant	Administrative staff who work “behind the scenes,” using a clinic’s EMR. PCCAs find patients who are due for care or screening. PCCAs call patients to offer an appointment with their physician, appropriate MDT, or a screening requisition.

PANEL AND CONTINUITY

Within the Medical Home Optimization priority initiative, the ESPCN supports clinics to improve panel identification, panel management processes, and continuity of care. This is a foundation of the PMH. Over half of ESPCN member clinics have continuous empanelment processes, defined as the identification of the family physician in the patient's chart, date stamping, panel categories, and confirmation at every appointment.

51.5%

of ESPCN clinics have continuous panelling processes

41.8%

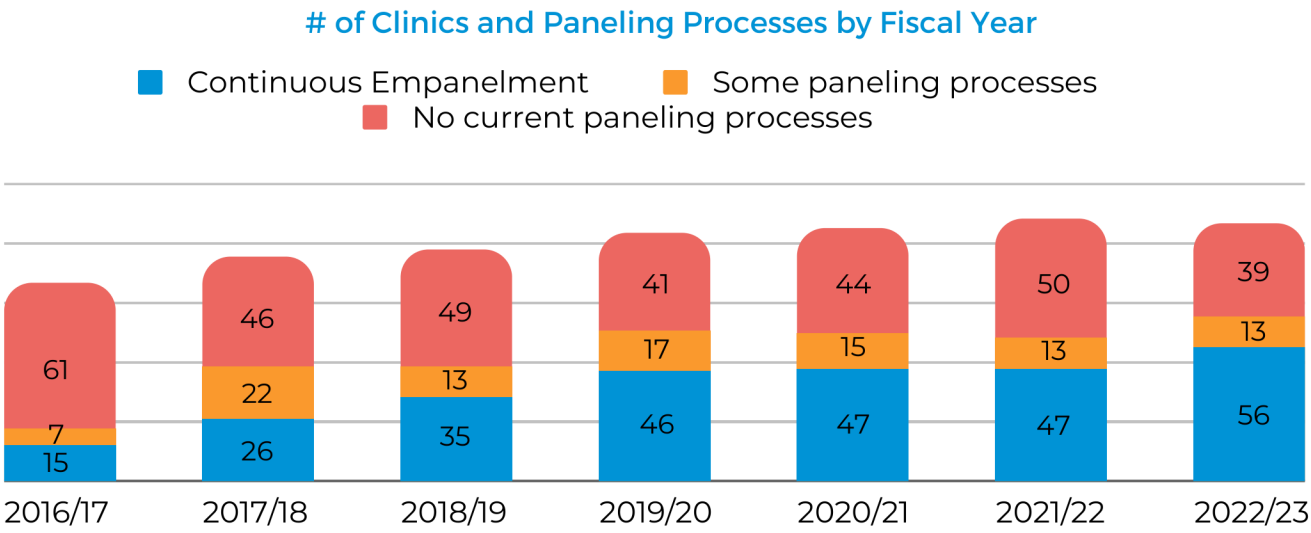
of member clinics have ongoing processes to call patients not presenting within 3 years

GROWTH IN PANELING

The number of clinics conducting panel outreach continued to rise: from 20.8% in 2020/21 and 39.1% in 2021/22, to **47.2% in 2022/23**

GROWTH IN PANELING

The establishment of a patient panel sets the foundation for all panel management and clinical care improvements. We continue to see increasing growth in continuous empanelment processes from 42.7% in 2021/22 to 51.5% in 2022/23. These rate increases are influenced by the ESPCN's capacity to introduce PCCAs into clinics. As of March 2023, 41.8% of member clinics had an ongoing process to review/call patients who have not visited their primary care provider in three years – consistent with the previous year.



PANEL OUTREACH - PROACTIVE MANAGEMENT

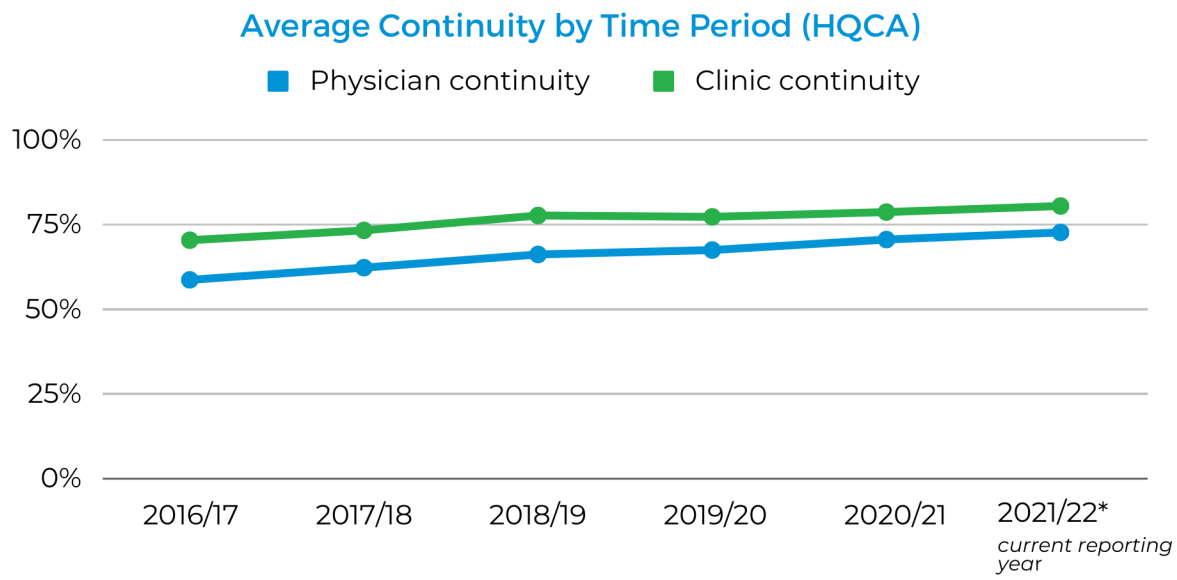
Being proactive in reaching out to patients is a critical component of panel management. The ESPCN encourages clinics to engage in outreach activities at set intervals based on one or more of the following criteria:

- time since last visit;
- clinical indicators, screening status; and/or
- age.

With the emphasis of PCCA work on outreach activities, the number of clinics conducting panel outreach in all four of these areas continued to rise from 20.8% in 2020/21 and 39.1% in 2021/22, to 47.2% in 2022/23.

MEASURING CONTINUITY - HEALTH QUALITY COUNCIL OF ALBERTA DATA

Each year the Health Quality Council of Alberta (HQCA) examines system data to estimate physician continuity. Research shows that patients with high continuity to a family physician show better health trends compared to patients with low continuity. The average physician continuity for ESPCN patients to their main family physician (72.7%) and clinic continuity (80.5%) have shown improved trends over time. ESPCN rates are on par with zone and Alberta panel averages.



COMMUNITY INFORMATION INTEGRATION AND CENTRAL PATIENT ATTACHMENT REGISTRY (CII/CPAR)

The Community Information Integration and Central Patient Attachment Registry (CII/CPAR) enables greater informational and relational continuity and continues to be a priority for all PCNs in the province. CII allows providers to send select patient encounter information from mapped fields in their EMR to contribute to Community Encounter Digests (CEDs) in Alberta Netcare. CPAR identifies relationships between patients and their primary care provider and sends e-notifications to providers when their patients are seen in the emergency department, have a hospital admission or have day-surgery.

Within the Medical Home Optimization priority initiative, the ESPCN supports clinics to improve panel identification, panel management processes, and continuity of care. This is a foundation of the PMH and a requirement for CII/CPAR participation.

To improve awareness and physician registration for CII/CPAR, the ESPCN QI team developed, and hand delivered, informational packages to all member physicians in the spring and summer of 2022.

In the first quarter of 2022, 27 physicians at 11 clinics completed CII/CPAR Confirmation of Participation (CoP) forms, increasing the percentage of physicians live or in the process of enrolling from 17% to 26% of eligible ESPCN physician members. The aim is for 60% of eligible ESPCN member physicians to submit a CoP by March 31st, 2024.

COMMUNITY DEVELOPMENT

The ESPCN partners with family physicians and their practices through the integration of MDT members. MDT often function as system navigators and patient coordinators, working with external organizations through both informal and formal arrangements to provide patient care.

Community Development works to bring together the ESPCN's social and community efforts and helps ESPCN to identify, develop and capitalize on community resources that will benefit our patient population. Within this priority initiative, the Seniors' Centre Without Walls (SCWW) continues to be successful community program. The ESPCN works to develop new community partnerships in other target populations including families and youth, mental health and addictions, seniors and healthy aging, and vulnerable populations.

The connections and relationships between social and community agencies is vital to succeeding in our common goal of healthy communities. The ESPCN works to capitalize on community resources that can benefit the patient population cared for by member physicians and the clinical team.

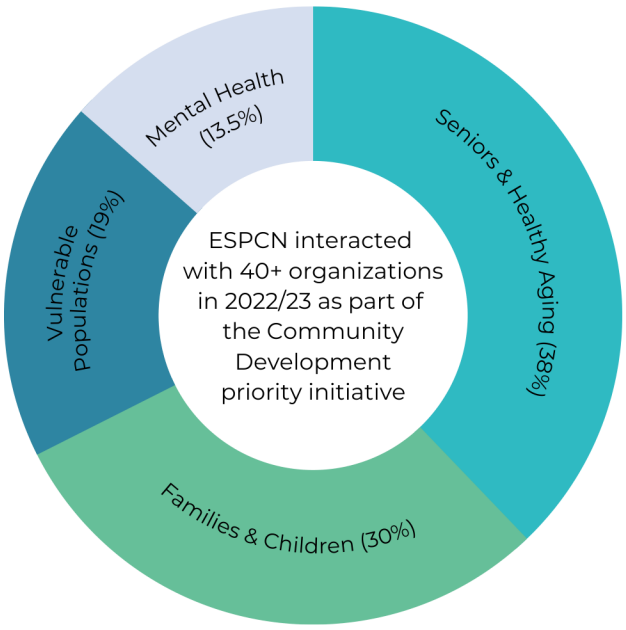
COMMUNITY PARTNERSHIPS

The Community Development priority initiative reinforces the ESPCN's commitment to enhancing community connections. ESPCN shifted to a proactive approach of developing community relationships and connecting directly with organizations rather than waiting for information requests. In addition, ESPCN staff attended four community trade fairs.

A new community liaison role was created in November 2022. The first objective of this role was to identify community organizations in our catchment area, as well as existing community collaboratives in the key priority areas. Interviews were conducted with 17 key community agencies to identify needs and opportunities for partnership.

In 2022/23 the ESPCN interacted with over 40 organizations as part of the Community Development priority initiative. This included:

- Introductory meetings and/or interviews to make new connections, assess community needs, and identify opportunities for future partnerships.
- Participation in community working groups and interagency connections
- Seniors Centre Without Walls partners
- Representation at community fairs
- Community presentations



SENIORS' CENTRE WITHOUT WALLS COMMUNITY PROGRAMMING

ESPCN partners with community groups as well as other PCNs to deliver health and recreational programming, welcoming referrals from across the province. Under the Community Development priority initiative, SCWW is a telephone-based "seniors centre" program for isolated and homebound seniors. In the last fiscal year, SCWW held over 900 individual program sessions, serving between 125-150 active participants each quarter. SCWW typically offers four programs daily with an average of 8-12 participants per program.

Approximately three-quarters of SCWW programming is run in partnership with guest presenters from other PCNs, community partners, and volunteers.

SCWW held over **900 individual program sessions**, including between 125-150 active participants each quarter

SENIORS' CENTRE
WITHOUT WALLS

MEDICAL NEIGHBOURHOOD

The Medical Neighbourhood includes other PCNs, all AHS in-patient and community services, specialty medical services and community agencies. The ESPCN collaborates with these agencies to integrate and align care to improve the experience and results for the population.

PHYSICIAN LEARNING PROGRAM

In 2022/23, the ESPCN and the Physician Learning Program (PLP) jointly hosted 5 workshops series, which included nine events in total, on the following topics: Heart Failure in Primary Care (2 parts), Obesity Management (2 parts), ADHD Across the Lifespan (3 parts), Diabetes and Hypertension (1 part), and Managing Lung Disease in Primary Care (1 part). Workshops were attended by participants across 16 Alberta PCNs. Each event had an average of 81 attendees, 38 of which being physicians.

BATTLING BURNOUT WEBINAR SERIES

The Battling Burnout Webinar series is a joint Edmonton West PCN and Edmonton Southside PCN offering that grew out of a physician networking event held via zoom in July 2022. The concerns identified in this networking event included:

- Increased administrative burden
- Financial unsustainability of clinics
- Difficulty finding physicians to join practices and finding locums
- Other obvious frustrations with government policies and lack of support for primary care

To address these concerns, in addition to advocacy at a system level and fostering collaboration within the zone, the ESPCN and EWPCN partnered to design a series of one-hour webinars.

The first webinar in this series, *Stop Charting at Night*, presented by Dr. Sarah Smith, was held in February 2023, and was offered zone wide. There were 79 participants and evaluation responses were very positive. Two additional webinars planned for April and June 2023 continue to delve into topics related to efficiency in practice and supports for physician burnout – including the benefits of having medical residents in practice and exploring the blended capitation funding model.

The partnership with EWPCN on this project highlights the importance of working collaboratively with PCN partners to support patients on their health journeys and physicians in practice.

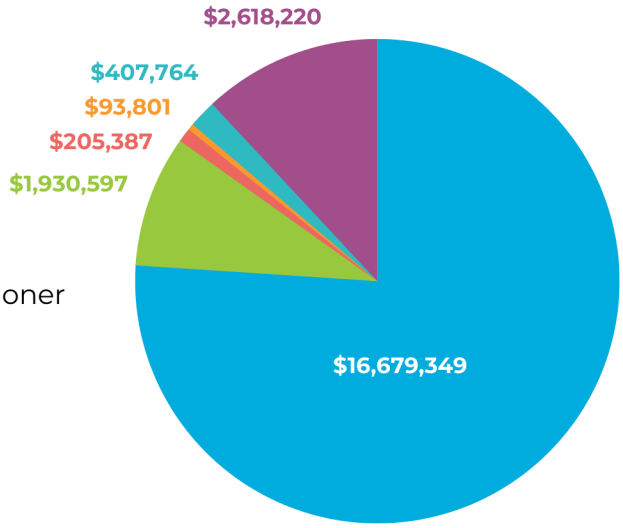
FINANCIAL STATEMENT SUMMARY

STATEMENT OF OPERATIONS

	2023	2022
	$	$
Alberta Health Grant - Operating	**21,431,219**	21,804,210
Alberta Health Grant - Capital	**471,642**	357,047
Business Plan Amendment	**480,250**	122,879
Other Grants	**32,256**	20,349
	22,415,367	22,304,485
Advertising	**45,968**	27,902
Allowance for goods and services tax receivable	**7,953**	49,435
Bank charges and fees	**2,446**	38,639
Catering expense	**3,511**	-
Contract services	**151,372**	101,796
Dues and subscriptions	**177,202**	168,072
Evaluation costs	**81,889**	92,957
Information technology	**246,173**	199,496
Insurance	**49,339**	42,694
Office and supplies	**62,113**	50,518
PAN PCN Contributions	**93,801**	96,100
Payments to physicians	**2,701,810**	2,896,551
Professional development	**71,586**	43,319
Professional fees	**41,520**	59,353
Rent	**509,864**	521,918
Repairs and maintenance	**12,047**	6,663
Small equipment purchases	**32,882**	9,017
Supported Therapy Pilot	**9,350**	-
Telephone and communications	**102,990**	85,314
Travel	**9,513**	4,144
Wages and benefit		
Administration	**1,708,148**	1,613,394
Clinical support	**3,602,531**	2,788,947
Health professionals	**12,219,717**	13,051,209
	21,943,725	21,947,438
Excess of revenue over expenses before other items	**471,642**	357,047
Amortization of capital assets	**(471,642)**	(357,047)
Excess of revenue over expenses for the year and net assets, end of the year	**-**	-

EXPENSES BY PRIORITY INITIATIVE

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



PAYMENTS TO PHYSICIANS

	2023	2022
	$	$
Services [1]	**98,594**	156,555
Multidisciplinary team overhead payments	**2,603,216**	2,739,996
	2,701,810	2,896,551

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

STAFFING SUMMARY

	2023		2022	
	FTE	**$**	FTE	$
Total Direct Care Provider Staffing	**107.05**	**12,219,717**	108.75	13,051,209
Total Clinical Support Staffing	**34.2**	**3,602,531**	27.7	2,788,947
Total Admin and Support Staffing	**16.5**	**1,708,148**	13.5	1,613,394
	157.75	**17,530,396**	149.95	**17,453,550**

The Statement of Operations and the Payments to Physicians was taken from Financial Statements audited by Ernst and Young

Primary Care Network
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