Primary Care Network
EDMONTON SOUTHSIDE

2023/2024 ANNUAL REPORT

Team-Based Care: Bridging Excellence & Innovation in Primary Care

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Edmonton Southside Primary Care Network

The Edmonton Southside Primary Care Network (ESPCN) was the first primary care network in Alberta, established in 2005. Over the past 19 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 care 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. Each medical home cares for patients with unique health care needs. By incorporating a multidisciplinary team model that is co-located in medical homes, physicians and teams can provide more holistic care to their patients.

What is a Primary Care Network?

A Primary Care Network (PCN) is an organization that works in their community to bring family doctors and a team of health care professionals together to provide collaborative patient care. Physicians work with a health care team that may consist of nurses, mental health professionals, social workers, and dietitians to provide integrated care within the patient's medical home. Each multidisciplinary team is unique to every PCN and the population that they serve.

What is a Patient's Medical Home?

Primary 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. A patient's medical home (PMH) puts each patient's needs at the centre of their care. It emphasizes prevention through primary care and connection to broader health services when needed. "The success of a PMH depends on collaboration and teamwork—from the patient's participation in their care, to interprofessional and intraprofessional care providers working together."[1] The ESPCN uses a team-based, patient-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 communities.

Land Acknowledgement

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.

1. https://patientsmedicalhome.ca/files/uploads/PMH2019Summary_ENG.pdf

REPORT FROM THE CHAIR:
ESPCN's Alignment with System Change Efforts

In October 2023, the Alberta government announced its plan to unify Alberta under a health care system centered around four priority areas: primary care, acute care, continuing care, and mental health and addiction. Within this plan, recommendations from the Modernizing Alberta's Primary Health Care System (MAPS) strategic advisory panel outline how Alberta Health is looking to strengthen primary health care delivery and ensure all Albertans have access to timely and appropriate primary health care services. The MAPS implementation plan focuses on seven key focus areas with recommendations intended to transform the current primary health care system – most of these are areas that ESPCN has been focused on for some time.

Transforming Governance, Strengthening, and Aligning Accountabilities

The first focus area in the MAPS report centres around governance and accountability. It describes the shift to regional primary health care networks and the establishment of a primary health care organization, as well as aligning primary care delivery under a new governance model. The recommendations involve reforming primary health care governance by establishing frameworks that support the patient's medical home.

ESPCN has built a strong leadership foundation from the Board of Directors and our executive leadership team, to the site-specific leadership, medical home optimization staff, physician champions, and clinic teams. ESPCN encourages teams to embrace a medical home optimization culture at the local level, advocating for quality improvement (QI) strategies at each member clinic.

This year saw the introduction of the medical director role, filled by Dr. Candy Marcet. This is a physician leadership position which reports to the board of directors and is responsible for providing clinical leadership in ESPCN programming and primary care service delivery. This past year, Dr. Marcet has focused on physician engagement, progressing the patient's medical home model, CII/CPAR enrollment, and exploring physician learning opportunities for member physicians through the Physician Practice Improvement Program (PPIP).

Evolving Patients' Medical Homes within an Integrated Health Neighbourhood

The recommendations under the focus area of evolving patients' medical homes within an integrated health neighbourhood are aimed at developing a system oriented around Albertans. The recommendations are geared towards a system that promotes patients' medical homes and ensuring everyone has access to team-based care by connecting the patient's medical home to the larger health neighbourhood. This also includes investing in quality improvement initiatives.

At ESPCN, we work hard to ensure our patients are connected to team-based primary health care. This includes integrating team members into the patient's medical home and improving our processes at the PCN's central office to reduce wait times.

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

This past year, over 70% of clinics had at least one integrated MDT. This enables patients to have better access to the care that they need from the comfort of their medical home.

70.8% of clinics had at least one integrated multidisciplinary team member

Behind the scenes, we've been integrating quality improvement initiatives like the proactive care coordination assistant, a role which focuses on patient outreach, screening and data reporting. Each individual process, team, and initiative work together to create an environment where the patient is at the centre of a team who cares for their health needs in a timely manner using documented, research-based activities.

Changes at the PCN's central office also enabled improvements in how patients access their care. This includes same-day referral processing and a patient waitlist, as well as program improvements such as the GLA:D rolling intake approach to streamline registration. By March 2024, an additional 41 patients were added to the GLA:D program, a 43% increase within 3 months.

Enabling the Primary Care Workforce to Improve Health Outcomes

The recommendations under the focus area of enabling the workforce to improve health outcomes talk about establishing and sustaining a healthy, engaged and diverse workforce who are supported in providing team-based care across the province. At the ESPCN, continuous learning and development are important to our organizational vision of being the trusted cornerstone of a healthy community and our values of respect, passion, dedication, collaboration, and innovation.

Our educators promote continuous professional learning across the organization and provide services that allow ESPCN employees to learn, develop, and improve in their roles and within the primary care setting. In May 2023, ESPCN conducted an annual MDT competency survey for all disciplines to understand the knowledge, skills, and competencies related to primary care practice. Results help to shape professional development, education, and strengthen the care that we provide for patients in our community.

In the fall of 2023, we surveyed patients attending MDT visits in their medical home. Of the 542 surveys collected nearly all patients indicated that their overall rating of the care received during their visit was either excellent or very good. We also conducted a central office patient experience survey where 91.4% of patients rated the care they received as excellent or very good, indicating a high level of patient satisfaction with the services provided by the ESPCN central office, and patients are at the centre of what we do.

Building Capacity in Quality, Safety, and Innovation

The focus area of building capacity in quality, safety and innovation aims to see improvements in the health system based on information-driven learning and evidence. The QI team at the ESPCN strives to create a culture of continuous improvement across all medical homes. With innovation as a core value of the ESPCN, our Medical Home Optimization priority focuses on integrating QI services into member clinics through various initiatives, including QI training and education, implementing targeted QI projects, collecting, and analyzing patient outcome data, and collaborating with other clinics and organizations to share best practices and lessons learned.

Digitally Enabling Primary Health Care

Establishing sustainable, patient-centered digital infrastructure for primary health care in Alberta, including improved integration and data-sharing capabilities is the goal of the focus area centred around digitally enabling primary care. The Community Information Integration and Central Patient Attachment Registry (CII/CPAR) enables greater information and relational continuity. This continues to be a priority for the ESPCN and we are working on increasing physician enrollment in the CII/CPAR program to improve care coordination and continuity.

Significantly Investing in Primary Health Care

The province has committed to a significant investment in primary care. At ESPCN, our investment in the patient's medical home and the team-based care model is best shown through our investment in our clinical supports and services priority area. We ensure that patients receive ongoing, comprehensive care that meets their individual needs by focusing on providing one-on-one patient care, group visits, and group programming.

Through the Transitions of Care program, ESPCN primary care RNs support monitoring discharges via Netcare, assessing for risk, and supporting care coordination for patients who have been in hospital. ESPCN maintained lower overall ED re-visit and readmission rates as well as avoidable emergency department visit rates compared to zonal and provincial levels. This tells us that ESPCN patients are not commonly going to the emergency department for reasons that should be addressed within the patient's medical home.

Programs like this support the core functions of the medical home by enhancing patient access, promoting continuity of care, and prioritizing patient and family-centered care. Over 76% of our funding is allocated to these areas, underscoring our commitment to comprehensive, patient-centered care.

Understanding our Diverse Population

ESPCN believes that being a diverse and inclusive organization improves our outcomes in all settings. The staff-led equity, diversity and inclusion (EDI) committee works to enhance awareness and understanding of our diverse patient population. Two important initiatives from this last year were all-staff indigenous awareness modules and conducting a poverty simulation with the United Way.

The indigenous awareness modules provided an understanding of Alberta's First Nations, Inuit, and Metis history, demographics, and focused on exploring the social determinants of health, cultural traditions, and worldviews of Indigenous people accessing care.

We also partnered with the United Way to conduct a poverty simulation for all staff. This organization-wide activity helped draw attention to the burden of financial strain and enhance clinicians' awareness of its affect on our patients. For our work with the United Way, ESPCN was awarded the Welcome to the United Way award which recognizes organizations that are supporting United Way for the first time. It also represents the investment that we've made in increasing our education and awareness of the challenges that many patients in our community face.

Looking Ahead

As implementation of the MAPS recommendations get underway, there are feelings of excitement and uncertainty throughout the PCN and the zone. It is apparent that staff, physician members, and PCN leaders are aligned with the need for improvement and investment in primary care. We look forward to being active contributors in these efforts towards system change.

2023-24 ESPCN Board of Directors

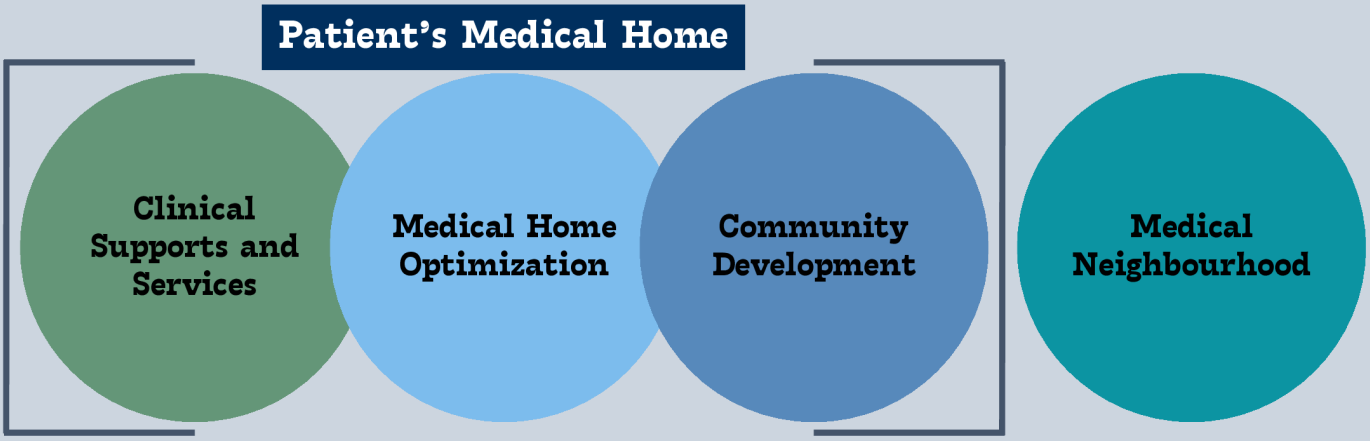
Saeed Ahmadinejad
John Chmelicek
Juliet Fairfax
Janine Karpakis
Freda Lo
Erin Park
Blake Pedersen
Ron Shute
Helene Tomasiuk-Donahue
Nathan Turner
Dawn-Ellen Young
Fozia Zakaria

Officers and Management

Juliet Fairfax, Chair, Board of Directors
Ron Shute, Vice Chair, Board of Directors
Andrea Atkins, Executive Director

Our 2024-27 Business Plan Priorities

Everything we do is guided by our business plan priorities and our commitment to patients and their medical homes. Our business plan identifies key priorities, including Clinical Supports and Services, Medical Neighbourhood, Medical Home Optimization and Community Development.



Clinical Supports and Services focuses on providing one-on-one patient care, group visits, and group programming. This supports the core functions of the medical home by enhancing patient access, promoting continuity of care, and prioritizing patient and family-centered care. Through this priority, we ensure that patients receive ongoing, comprehensive care that meets their individual needs.

Medical Home Optimization supports the diverse needs of the ESPCN community and physician panels, by focusing on the optimization and enhancement of each patients' medical home. Our quality improvement team (improvement facilitators, EMR consultants and proactive care coordination assistants) assists medical homes with developing goals and actionable processes.

Community Development activities seek to strengthen the connections and relationships between individuals and organizations and to increase capacity within communities to work towards our common goal of healthy communities. This initiative enables ESPCN to develop thoughtful and intentional partnerships that strengthen collaborative efforts to influence the overall health of our community.

The **Medical Neighbourhood** 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 our patients.

2024-27 ESPCN Business Plan Highlights

Every three years, we renew our business plan. Initiatives in our renewed business plan for 2024-27 reflect ESPCN's commitment to continuous improvement, team-based, patient-centered care, and addressing the diverse needs of our patient population.

Notable initiatives in ESPCN's plan for 2024-27 include:

Aligning service delivery to how patients want to receive healthcare services

It is important to meet patients where they are at in their healthcare journey. We are focused on aligning our services to meet the specific needs of our patient populations. This patient-centered approach to care is demonstrated through the addition of initiatives like our registered dietitian group visits, supported therapy pilot, and central social worker role.

Focus on access improvement within medical homes

From initiatives to reduce wait times for referred services to enhanced appointment scheduling processes and enabling timely access, we are focused on opening doors for patients to the services they need, when they need them.

Investment in data architecture

By refining our ability to collect, analyze, and use data, we can enhance our ability to make evidence-based decisions. Our investment in data architecture supports decision-making, quality improvement efforts, and the monitoring of patient outcomes.

Investment in equity, diversity, and inclusivity (EDI)

High-quality patient care begins with understanding the diverse needs of the people we care for. We have dedicated resources and efforts towards promoting EDI within our organization to ensure all patients receive equitable and quality health care services.

2023-24 ESPCN Stats

353
Member Physicians

185
ESPCN Staff

114
Member Clinics

157,646
patient encounters

67,679
total patients

53.9%
of clinics have integrated PCCA support

Top Ten MDT Encounter Types
(2023-24)

Patient Feedback

Of the 542 patient surveys collected, nearly all patients indicated that their overall rating of the care received during their visit was either excellent or very good.

% of patients who indicated the care received in their visit was excellent, very good or good in the ESPCN patient surveys:

99%
Registered Dietitians

98%
Primary Care Registered Nurse

96%
Behavioural Health Consultant

Growth in Paneling

the percentage of ESPCN physicians routinely verifying their panels continues to increase, from 65.0% in 2022-23 to 78.5% in 2023-24.

Transitions of Care

73%

of high-risk patients who were admitted to a hospital received follow-up by primary care within seven days of discharge and had a lower number of emergency department re-visits (27%) than those without follow-up (29%)

SENIORS' CENTRE WITHOUT WALLS

SCWW held over 900 individual program sessions, including:

137 mental health and positive well-being sessions

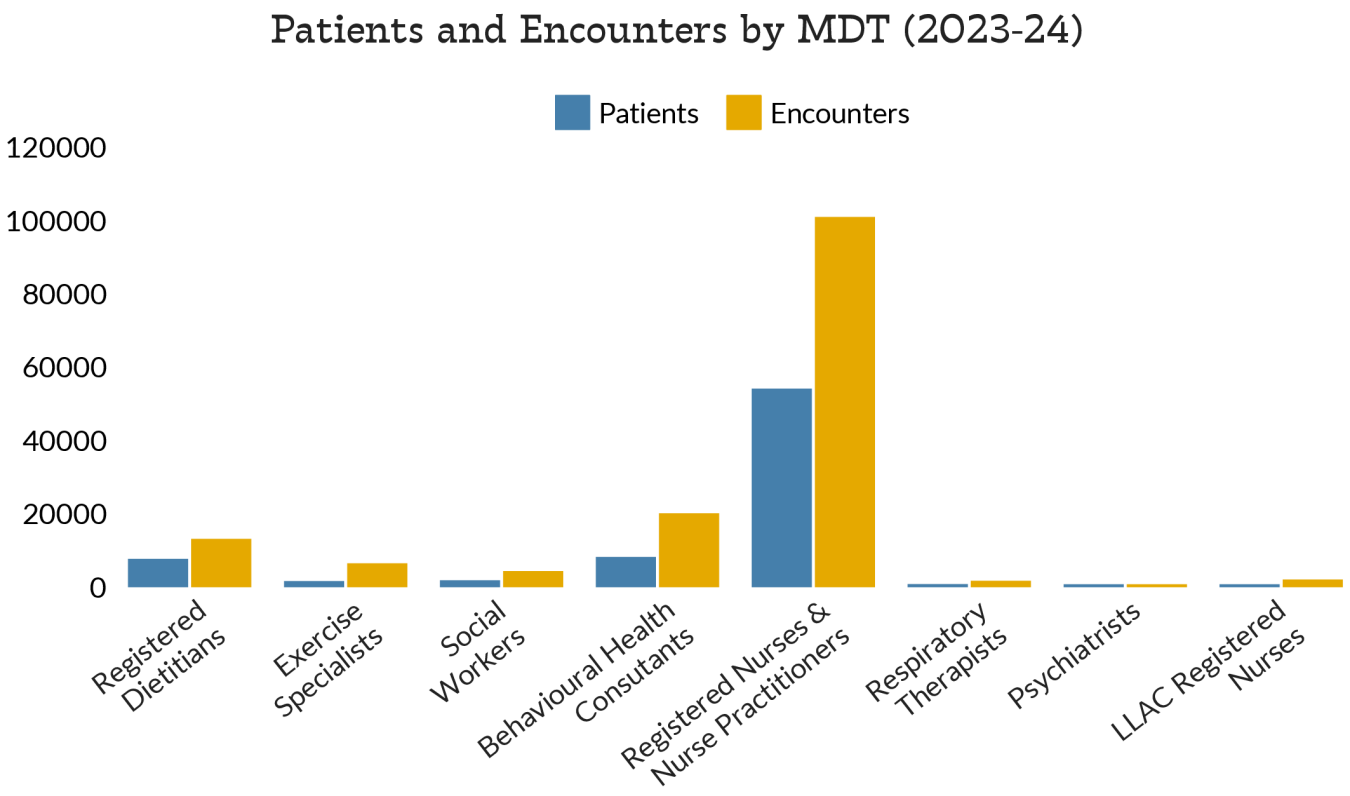
130 one-hour exercise programs

30 physical health sessions

Team-Based Care: A Core Patient's Medical Home Pillar

Multidisciplinary Teams

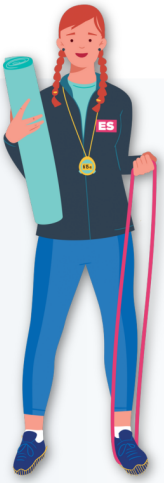
One of the foundations of the patient's medical home is increasing access to team-based care. ESPCN builds teams of health professionals to support and extend the care provided by its member physicians. Multidisciplinary teams (MDT), in partnership with member physicians, focus on complex populations such as patients living with multiple chronic health conditions, seniors, and those with psychosocial challenges. Most member clinics (70.8%) had at least one integrated MDT in 2023-24.



185 ESPCN staff work with 353 family physicians from 114 member clinics to offer compassionate, comprehensive team-based care to patients. Access to one-on-one patient appointments with MDT is also offered through the ESPCN central office in addition to other programs and services, including group education workshops, exercise specialist programs and services, respiratory therapist care, consulting psychiatry, and our Lower Leg Assessment Clinic. One significant advantage of co-location is the large volume of encounters (157,646) and patients (67,679) served by ESPCN MDT. The co-located model forms the foundation for the bridge that connects patients from their family doctor to their MDT, services, and programs that support their medical homes.

One significant advantage of co-location is the large volume of enounters (157,646) and patients (67,679) served by ESPCN multidisciplinary team members.

Multidisciplinary Team Members



Exercise Specialists (ESs) promote and prescribe physical activity to prevent and manage chronic health issues.

They work with patients who have diagnosed chronic conditions as well as support patients through the behaviour change needed to improve or modify their physical activity.

Primary Care Registered Nurses and Nurse Practitioners (PCRNs and NPs) provide comprehensive nursing services and care to patients in primary care.

They provide assessment, screening, healthy lifestyle support, education, self-management support, and chronic disease management across your lifespan, with a goal of improving health outcomes and facilitating access to services. This involves a comprehensive, holistic, patient-centred approach, and may vary based on the needs or population they serve.

Behavioural Health Consultants (BHCs) usually a registered social worker, an RN, or registered psychiatric nurse (RPN), BHCs work to address chronic and mental health concerns through evidence-based behavioural interventions.

Any patient whose health is impacted by their habits, behaviours, thoughts, and emotions would benefit from a referral to a behavioural health consultant.

Registered Dietitians (RDs) are uniquely trained to advise on food and nutrition for overall health and wellness.

They are recognized as nutrition experts who are qualified to provide medical nutrition therapy for the prevention, delay, and management of disease and illnesses.

Respiratory Therapists (RTs) assess and manage people living with respiratory illnesses. They assist in the planning, implementation, and evaluation of respiratory care plans. They are knowledgeable on the current treatment guidelines and medications for chronic lung diseases.

Social Workers (SWs) support patients of all ages to address barriers and provide access to appropriate services.

They assist in connecting patients with financial, housing, employment, and health services. They can also help patients with their personal directives and enduring power of attorney documents.

Promoting Excellence and Innovation

Quality Improvement

The quality improvement (QI) team at the ESPCN strives to create a culture of continuous improvement across all medical homes. ESPCN supports clinic teams through investment in our health transformation workforce including improvement facilitators (IFs), EMR consultants (EMR-Cs), and proactive care coordination assistants (PCCAs).

Integrating Clinical Services and Quality Improvement

ESPCN has focused on integrating QI services into member clinics through various initiatives, including:

- QI training and education for staff members
- Implementing QI projects targeting specific areas of care
- Collecting and analyzing data related to patient outcomes and clinical processes
- Collaborating with other clinics and organizations to share best practices and lessons learned

Integrating quality improvement services into clinics is an important aspect of enhancing the overall quality of care and patient outcomes. ESPCN focuses on using QI support to optimize care provided by the MDT. In 2023-24, 57.3% of ESPCN clinics had a QI project or process involving MDT to optimize team-based care. Clinics are supported to measure data related to these projects to inform process improvement.

In 2023-24 57.3% of ESPCN clinics had a QI project or process involving MDT to optimize team-based care.

Quality Improvement Team Members

- **Improvement Facilitators** work with family doctors and other members of the Patient's Medical Home to develop an action plan on priority areas and coordinate support from the rest of the quality improvement team.
- **EMR Consultants** support clinics by building EMR reports, giving template support, and advising on EMR optimization.
- **Proactive Care Coordination Assistants** provide practical support for ongoing panel management in clinics.

Proactive Patient Outreach

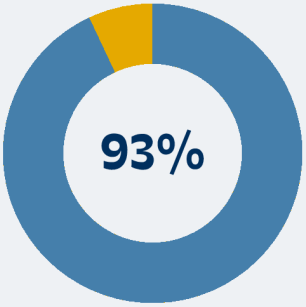
In November 2022, we introduced the Proactive Care Coordination Assistant (PCCA) role). PCCAs are administrative staff who work behind the scenes using a clinic's EMR. The PCCA is an integral member of the care team and is responsible for proactively contacting patients with gaps in their care or who are overdue for preventative health screening.

As of March 31, 2024, 73% of physicians with panels and using EMRs that can run reports received PCCA support, up from 70% the previous year.

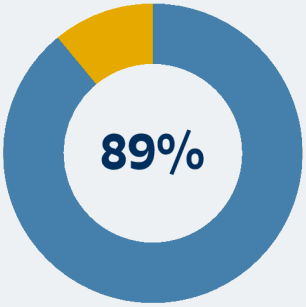
PCCAs ensure patients are connected to their medical homes during each phone call by confirming patient-physician attachment, booking appointments with the physicians or PCN multidisciplinary team members, or directly offering patients screening requisitions and FIT kits. This enhances panel accuracy, continuity of care, and preventive health screening.

This program serves as a safety net to prevent vulnerable patients from falling through the cracks in our health system. With a collaborative approach between PCCAs, IFs, and family physicians, pathways that positively impact patient outcomes open up. ESPCN's goal is for 95% of patients to be seen in the recommended timeframe.

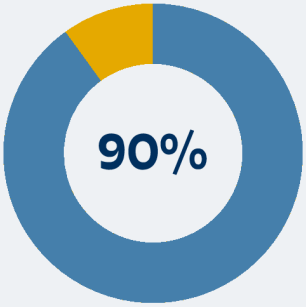
The PCCA Difference (June 2023 to March 2024)



of all patients had been seen by their physician within 3 years, up from 90% in June 2023.



of patients over age 75 had been seen by their physician in the past year, up from 85% in June 2023.



of patients with a chronic disease (diabetes, heart disease, hypertension, COPD, kidney disease) had been seen by their physician in the past year, up from 88% in June 2023.

Improving Patient Outreach

One of the responsibilities of our proactive care coordination assistants (PCCAs) is to work with family doctors on outreach initiatives, like reaching out to patients who are due for preventative screenings. Our PCCAs collaborate with clinic staff and other quality improvement team members to tailor their outreach strategy to meet the unique needs of different patient populations.

One ESPCN member physician has a high population of new Canadians, many of whom are from regions with little to no preventative health screening, including women's health procedures. As a result, the PCCA who called patients due for Pap screenings at this clinic was often met with hesitation about this procedure.

Rather than let these patients fall through the cracks, the improvement facilitator and the PCCA met with the health care team at this clinic, and together they made changes to their process to suit the patients at this clinic. Instead of calling patients to make an appointment for a Pap screening, the PCCA invited these patients to a book a women's health visit with a female nurse in their clinic. During these appointments, the registered nurse would complete an assessment, determine the patient's eligibility for a Pap screening, and complete that screening if the patient was comfortable with it. The RN also added the option of booking a follow-up visit for the actual pap exam so the patient was not pressured to do that test that day.

This small change led to an additional 101 patients screened for cervical cancer at this clinic.

By implementing evidence-based strategies that are motivated by comprehensive equitable patient care, our quality improvement team continues to enhance overall patient care.

Community Information Integration and Central Patient Attachment Registry

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.

The ESPCN is working on increasing physician enrollment in the CII/CPAR program to improve care coordination and continuity.

In 2022, ESPCN set a goal to increase physician enrollment in CII/CPAR from 17% to 60% within a 15-month timeframe. Several strategies were implemented, including setting quarterly targets, tracking process goals, and implementing a targeted communications strategy.

In 2022-23, ESPCN improved this number to 26% in the first quarter. As of March 2024, the physician enrollment rate reached 52% and 103 Confirmation of Participation forms were completed. We plan to adapt its processes and aim to achieve a future enrollment goal of 70% in 2024-25.

ESPCN also set a goal to reduce our overall CPAR conflict rates to below 3%. Conflicts exist when a patient is listed on multiple physicians' panels. Conflicts can cause duplication of physician work, reduced informational continuity for patients, and reduced access for patients to get new doctors. PCCAs support this work by calling patients, asking them to confirm who they consider their main provider, and updating physician lists. As of March 2024, ESPCN's conflict rate was 5.7%, which is below the Edmonton zone rate of 8.9%, and the provincial rate of 8.8%.

Improving Panel Accuracy to Support Patient Care

Panel accuracy enhances patient care by reducing duplication of physician work and increasing continuity of care within a patient's medical home. Our PCCAs, improvement facilitators, and primary care managers work with clinic staff behind the scenes with member physicians to decrease their conflict rate.

At one clinic, our quality improvement team worked together to confirm a process for the PCCA to contact patients on a conflict report to confirm their attachment. Since starting this process in September 2023, the clinic average has decreased from 3.85% to 3.24%, with eight of twelve physicians already meeting the less than 3% conflict rate goal.

Overall, our goal is for each ESPCN physician to have a conflict rate that is less than 3%. With the ongoing use of this process, we will continue to see a decrease in conflict rates, which will enhance efficiency for family doctors and increase access for new patients.

Team-Based Care Optimization Projects

ESPCN engages in team-based care optimization projects to enhance the quality and safety of care delivered by multidisciplinary teams. Key team-based care optimization projects for ESPCN in 2023-24 included establishment of primary care manager clinical leads, integrating clinical services and QI, measuring MDT competencies, a PCRN working group, expansion of the Lower Leg Assessment Clinic, a COPD/Asthma Clinic pilot, and clinical outcome measurement.

New Clinical Program Leads

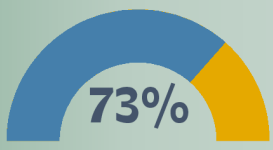
Clinical lead roles were established in 2023-24 to provide program leadership to advancing clinical service goals and supporting clinical program development. Primary care managers assigned to these lead roles are responsible for overseeing clinical educators, ensuring alignment of orientation, and developing strategies to ensure competency. They provide leadership by co-chairing discipline meetings and providing oversight on relevant tools and resources. In addition, they lead evaluation plans for each clinical area (supported by the evaluation manager), and spearhead the implementation of projects and process improvements.

Coordinating Care Transitions

Primary care follow-up after a hospital stay is a proven strategy for reducing hospital readmissions. In 2015, ESPCN modified a Readmission Project from Kaiser Permanente to support reliable and consistent follow-up for patients discharged from hospital.

As part of the Transitions of Care (TOC) program, PCRNs support monitoring discharges, assess for risk, and support care coordination for patients who have been in hospital. ESPCN has maintained lower overall emergency department re-visit and readmission rates as well as avoidable emergency department visit rates compared to zonal and provincial levels. This indicates that ESPCN patients are not commonly going to the emergency department for reasons that should be dealt within the patient's medical home. By ensuring smooth and coordinated transitions for patients, patients are better able to access the care they need in the comfort of their medical home and from the physician or health care team who knows them.

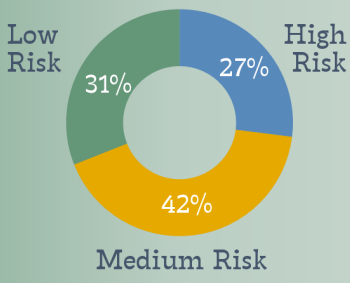
In 2023-24, 6,970 ESPCN patient discharges were reviewed by the PCRN, 27% of which were identified as high risk. Of those high-risk patients, 73% were contacted for follow-up by the PCRN within 7 days of discharge and had a lower number of emergency department re-visits (37%) than those without follow-up (29%).



of high-risk patients received follow-up by primary care within 7-day target.

6,970

patient discharges from hospital reviewed by the primary care RN.



High-risk patients with 7-day follow-up had a **lower proportion of emergency department re-visits (27%)** than those without follow-up (29%)

617

patients received a follow-up call from the primary care RN.

Supporting Professional Development

Education for any health care professional is a continuous journey, and we are dedicated to supporting the development of our staff every step of the way. In May 2023, ESPCN conducted an annual MDT competency survey to understand the knowledge, skills, and competencies related to primary care practice. This survey, which is completed for each discipline, encourages self-reflection on competency levels, scope of practice activities, areas for personal growth and development, and topics for future education sessions. Results were reviewed by the PCM project leads and clinical educators to shape professional development education and strengthen the care that we provide for patients in our community.

Optimizing Scope of Practice

The PCRN working group supports care coordination activities by our PCRNs. Operating in the context of primary care, this group works to:

- optimize team-based care by focusing on the role and contributions of PCRNs;
- collaborate and provide input on the development and implementation of the PCRN role;
- develop an action plan to optimize full scope PCRN practice and enhance the integration and utilization of RNs;
- address the strengths and challenges currently faced by PCRNs;
- review external documents that influence primary care nursing practice;
- promote the interests and well-being of registered primary care nurses;
- address issues related to the nursing profession within the healthcare system;
- focus on quality improvement initiatives and optimization of nursing practices within the ESPCN; and
- promote best practices, standardize nursing protocols, and improve the overall quality of nursing services provided by the PCN.

Lower Leg Assessment Clinic Expansion

A second full-time PCRN joined the Lower Leg Assessment Clinic (LLAC) in 2024 following a surge in referrals of complex patients. These specially trained and certified RNs support patients with prevention and active treatment of lower leg edema, high-risk foot issues, wounds, peripheral arterial disease, and associated pathologies. Our LLAC RNs see many patients with more than one comorbidity that poses significant risks to their overall health and well-being, making it increasingly important that patients have a clear path between their family doctor and team of health care providers. The top three complex comorbidities seen by the LLAC are advanced diabetes with complications (29.8%), significant peripheral vascular disease (25.2%) and advanced cardiovascular disease (11.9%), significantly impacting a patient's quality of life and overall health.

The top three complex comorbidities significantly impacting a patient's quality of life and overall health:

29.8%	**Advanced diabetes with complications**
25.2%	**Significant peripheral vascular disease**
11.9%	**Advanced cardiovascular disease**

Comprehensive Care for Patients Living with Diabetes

The healthcare team at one of our member clinics identified that many of their patients living with diabetes would benefit from an annual foot exam. This important but time-consuming task can overwhelm busy family doctors. Outreach support for preventative care, such as the support this clinic needed to create and carry out a process for annual diabetes foot exams, is one of the ways our quality improvement team support family doctors to keep their patients from falling through the cracks.

For this project, our clinic PCCA contacted eligible patients to schedule foot exams with a registered nurse or family doctor. As a result, 81% of the diabetes foot exams completed in a 12-month period at this clinic were due to this outreach. The success of this work has led the clinic to adopt this process into the PCCA's ongoing role, so patients overdue for foot exams do not fall through the cracks" or something along those lines to show sustainability.

With the team's expansion, the LLAC can now address complex issues promptly, offering patients urgent treatment, education, and connection back to their medical home. Wait times for patients, as measured by TNA, also decreased from 21 days (about 3 weeks) to 1-2 days following the increase in staffing. This has greatly reduced the wait times for urgent referrals for patients needing wound assessments or treatments and post-hospital discharged patients with lower leg conditions. **Evaluation data showed a reduction of lower leg related visits to the emergency department by 43%.** A further review of evaluation data is scheduled for next year.

Optimizing Programs

The COPD & Asthma Clinic was launched this year and addresses a gap in primary care and community-based COPD and asthma services while increasing our central RT utilization. The team behind this pilot developed a standardized charting template, using assessment tools, and clinic marketing to raise awareness. The first evaluation of the clinic identified opportunities to leverage primary care team collaboration in caring for patients with COPD and asthma. These insights have been important in guiding the direction of the clinic in its second pilot year as we continue to work to optimize patient care.

Groups and Workshops

ESPCN offers group workshops at the central office to complement the work done in clinics and provide patients with more options to improve their health. In 2023-24, ESPCN offered five non-referral groups:

Non-referral groups:

- Changeways
- Emotional Regulation
- Prenatal
- Personal Directives/Enduring Power of Attorney
- Seniors' Centre Without Walls

Referral-based groups:

- GLA:D® Back
- GLA:D® Hip and Knee
- Moving for Memory
- Breathing for Health

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, Seniors' Centre Without Walls (SCWW) is a telephone-based "seniors centre" program for older adults who find it difficult to leave their home to participate in social activities. This year, SCWW held over 922 individual program sessions. SCWW typically offers four to five programs daily with an average of almost nine participants per program.

Various organizations including PCNs, Edmonton Public Library, Parks Canada, and the Canadian Mental Health Association, support SCWW programming by hosting, co-hosting, and helping to develop materials for programs. Approximately three-quarters of SCWW programming is run in partnership with guest presenters from other PCNs.

Connections forged through SCWW phone-based programming signals high levels of satisfaction among participants, as well as improvements in their perceptions of companionship and loneliness. In 2023-24, participant feedback (collected through spot checks, quarterly advisory sessions, and individual outreach calls) led to the creation of a new community newsletter and a redesign of the program materials.

In the last fiscal year, SCWW held over 900 individual program sessions, including:

137 mental health and positive well-being sessions

130 one-hour exercise programs

30 physical health sessions

Enhancing the Patient Experience

Collaboration is the foundation of care for patients in our community. The ESPCN connects our team of health care providers to the patients that need them through the family doctor that cares for them. Our team approach promotes the valuable relationship between family physicians and their patients with the broader services and larger philosophy of the PCN. This connection of people and services offers the greatest benefits to individuals, families, and the health system.

Our highly trained multidisciplinary team is a valuable resource for physicians because they help to provide enhanced primary care at clinics and in the community through specialized training, programs, and services. The multidisciplinary staff collaborate with other teams at the ESPCN, like our central office and quality improvement team, to develop programs and strategies tailored to the needs of each clinic and patient population.

A total of 132 patients were surveyed and 91.4% rated the care they received as excellent or very good.

Central Office Process Improvements

In March 2024, we conducted a survey of patient experience with our ESPCN central office. A total of 132 patients were surveyed, and 91.4% of patients rated the care they received as excellent or very good. Patients reported positive experiences with accessing the location, front reception welcome, check-in process, and understanding the reason for referral to the ESPCN central office. The acceptability of wait time also increased from 93.1% in March 2023 to 97.7% in March 2024.

These survey results indicate a high level of patient satisfaction with services provided by the ESPCN central office. The results highlight the clinical improvements made at the ESPCN central office, including:

Same-day referral processing & waitlist

Enhancing access to central services includes improving how we process patient referrals to the central office. Referrals are now processed on the same day they are received. Additionally, a new referral waitlist has been established. When there is a waitlist, both the physician and the patient receive a notification letter ensuring timely communication with all parties.

These process improvements allow for more accurate resource planning by understanding the true demand for referred services.

Using data to drive improvements

A central measurement plan was established to better understand how central services are accessed. This plan helps track and measure key performance indicators related to access and utilization, allowing for data-driven decision-making and continuous improvement. ESPCN monitors data including referral volumes, supply and demand, processing times, and wait times for services.

As of March 2024, most centralized PCN services were within the defined targets.

Program improvements

In January 2024, ESPCN introduced a rolling intake approach for the GLA:D® Back program. The aim was to ensure anyone who has been referred to the program, assessed, and has attended the required education can join a group within three months of the referral.

By March 2024, an additional 41 patients were added to the program, a 43% increase since the rolling intake was adopted.

This, coupled with improved referral management, halved the number of patients on the waitlist (from 300 to 122) and reduced the wait time from over 10 months to 3-4 months.

By streamlining the referral process, improving communication, and implementing a measurement plan, the ESPCN can provide better care coordination and ensure timely access to the services patients need.

Measuring the Patient Experience

Giving our patients the opportunity to provide feedback helps us understand their experiences - a key part of patient-centered care. It tells patients they are valued and respected, and that we care what they think. It is an opportunity for patients to share their perspectives and can help generate ideas for improvement at both clinic and PCN levels.

In the fall of 2023, the ESPCN surveyed patient experiences with select disciplines including the primary care registered nurse, behavioural health consultant and registered dietitian. Of the 542 surveys collected nearly all patients indicated that their overall rating of the care received during their visit was either excellent or very good. While we regularly collect patient feedback for central programs and services, and have helped clinics do their own patient surveys, this is ESPCN's first time collecting patient feedback focused on those patients seeing MDT in clinics.

Measuring Patient-Centred Care

	PCRN	BHC	RD
% of patients who indicated the care received in their visit was **excellent**, **very good** or **good**.	98%	96%	99%
They listened to me *(agree/somewhat agree)*	100%	97%	97%
They involved me in decisions about my care *(agree/somewhat agree)*	100%	97%	96%
They explained things in a way I could understand *(agree/somewhat agree)*	100%	95%	96%

Removing Barriers to Preventative Health Screening

Our quality improvement team collaborates with ESPCN member clinics to develop processes that remove barriers to patient care. One of these processes includes the PCCA Requisittion Protocol, which is part of our patient outreach strategy. One doctor receiving this support saw increased mammogram and colorectal cancer screening rates (66% to 73% and 74% to 77%, respectively) and a decrease in their appointment wait times from 39 days to 15 days during the same period.

How did this happen? As part of the PCCA Requisition Protocol, the PCCA can directly offer eligible patients screening requisitions rather than booking the patient in to see the doctor first. This removes barriers for patients, who may face challenges attending screening appointments in clinics. It also frees up appointment spots at the clinic, with the physician appointments only going to patients with screening results requiring follow-up.

RD Triage Process Improvements

In early 2023, a new triage process was inititated for patients referred for RD services at the central office. Patients are offered a 1:1 appointment or group visit based on the reason for referral. Referrals that are unclear are booked for a 15 minute triage call to help determine the appropriate service. Since implementing these changes, a significant number of referrals are navigated directly into group visits. Within the first 6 months, approximately 40% of referrals were booked for 1:1 appointments, 48% for a group visit based on a chronic condition, and 12% for a 15-minute triage call with an RD.

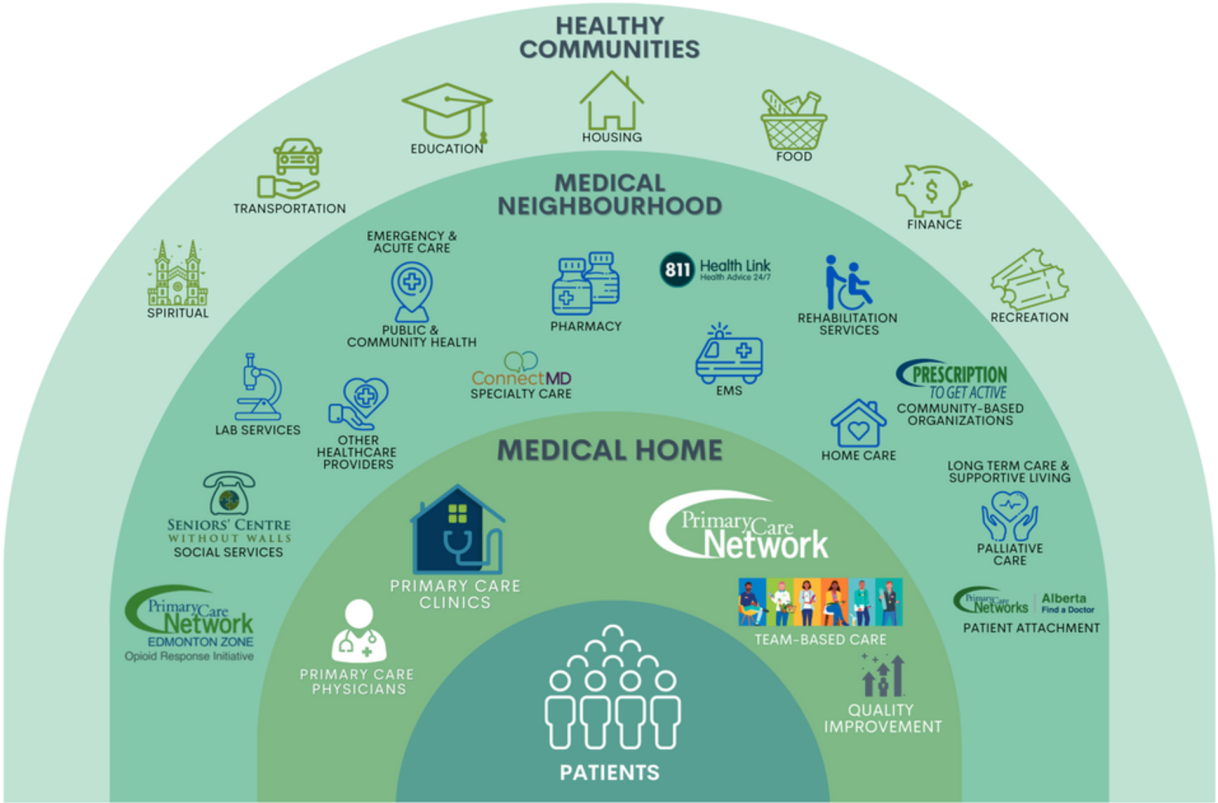
Through this process, we can offer timely access to RD services that is tailored to the patient's needs. Patients are able to access a group visit for diabetes management, heart health, or healthy eating, and are typically able to access this service within seven days from the first point of contact. Patients can continue building nutrition knowledge, accountability with goal setting, or support with nutrition behavior change through attending additional group visits as the content is tailored based on topics brought forward by participants. If needed, patients with nutrition concerns beyond the scope of the group visits are directed to follow up 1:1 with an RD for more support.

Supported Therapy Pilot

The Supported Therapy Pilot (STP) was officially launched in February 2023, marking a significant step in our commitment to enhancing mental health services. The STP provides up to six fully subsidized counselling sessions to a patient from a registered psychologist or registered provisional psychologist in partnership with Cornerstone Counselling. There are three main eligibility criteria for access to the pilot:

Household income equal to or less than $100K	Demonstrated motivation and readiness for counselling as assessed by the BHC.	No access to non-insured health benefits covering psychological services

The results of the STP include a total of 1,444 patient appointments, 799 assessments, and over 600 referrals. Preliminary patient experience surveys showed positive feedback with high rates of referral appropriateness, comfort in explaining needs, readiness for therapy, completion of therapy, and satisfaction with therapy. The impact of therapy was also rated highly by patients. A full evaluation report will be prepared at the end of the pilot in 2024-25.



Advancing Awareness of our Diverse Communities

The ESPCN believes that being a diverse and inclusive organization improves our outcomes in all settings. In 2021, the ESPCN began a working group focused on equity, diversity, and inclusion (EDI), which was formalized into an employee-led committee in 2022. The committee organizes education to enhance awareness and understanding of our diverse patient population.

Expanding Cultural Awareness

In keeping with the ESPCN's commitment to Truth and Reconciliation and to provide culturally sensitive and patient-centered care for Indigenous populations, all ESPCN staff were required to complete Indigenous Awareness modules in early 2024 through the Alberta Health Services (AHS) training portal.

The modules provided learners with an understanding of Alberta's First Nations, Inuit, and Metis history, demographics, and current issues. They focused on exploring the social determinants of health, cultural traditions, and worldviews of Indigenous people accessing care. Additionally, the modules assisted learners in developing awareness of how the health system can better meet the needs of Indigenous patients and families.

Exploring Social Determinants of Health

In November 2023, ESPCN partnered with the United Way to conduct a poverty simulation for all staff. "A Poverty Simulation is a unique and powerful experience which challenges perceptions, changes perspectives and strengthens understanding and empathy…The simulation replicates a month in the life of a family living in poverty. The ultimate mission of each of these families is to provide food, shelter and other basic needs with a limited income." (myunitedway.ca/partner-with-us/employee-engagement/poverty-simulation/)

For our work with the United Way on this Poverty Simulation, ESPCN was nominated for, and a recipient of, a Welcome to the United Way award. This award recognizes organizations that are supporting United Way for the first time. Eligible candidates demonstrate a commitment to the community by empowering individuals to get involved in the community and make a difference.

This award is a testament to the incredible work of the poverty simulation working group. This group consisted of staff who expressed interest, enthusiasm, and commitment to promoting awareness and empathy among their peers. In addition to the contributions of the working group, the poverty simulation would not have been a success without the volunteers who put up their hands to make the simulation running smoothly.

PCN Process Improvements Following the Poverty Simulation

Following the Poverty Simulation, all clinical discipline groups participated in debriefs facilitated by the clinical educators and management leads for each discipline. The debriefs focused on the impact of the Poverty Simulation on everyone's practice, key learnings, and awareness of the social determinants of health.

We anticipated an increased demand for our centralized social worker support due to the increased awareness of the social determinants across the organization. As a proactive step for this support, we developed a social work referral decision tree to promote capacity building for all clinical disciplines to offer guidance for clinicians to refer to the social worker where most appropriate and needed. We also expanded our social work FTE and have been working to optimize the efficiency of the role.

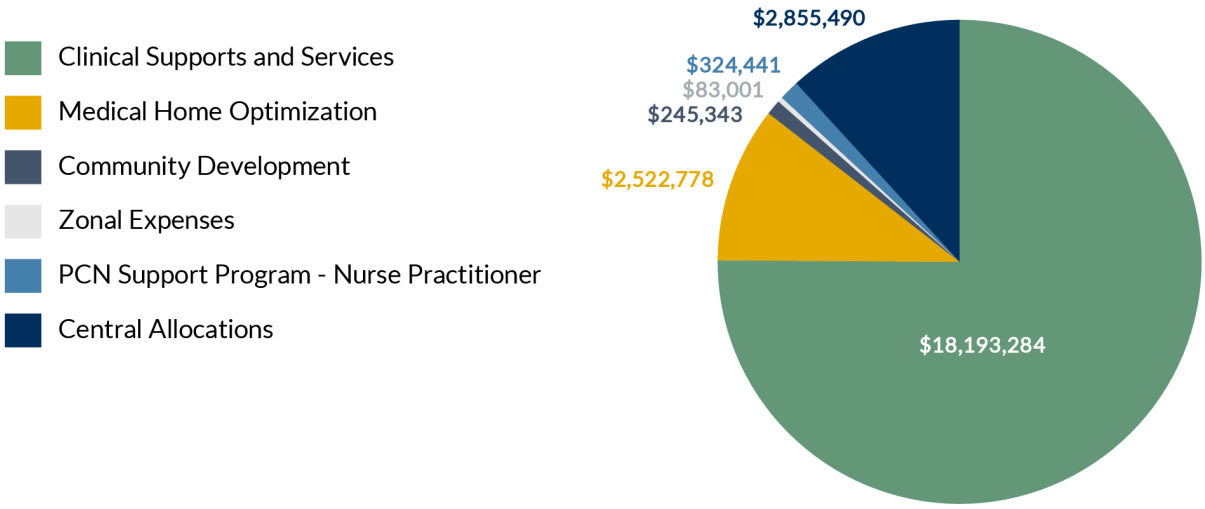
Further, in our COPD & Asthma Clinic, we are currently piloting a poverty screening for all patients during their initial assessment. The screening is a single question: do you have difficulty making ends meet? If patients screen positive, they are offered a phone triage appointment with a social worker and subsequent follow up to ensure they receive the appropriate support.

Financial Statement Summary

Statement of Operations

	2024	2023
	$	$
Alberta Health Grant - Operating	**23,070,811**	21,431,219
Alberta Health Grant - Capital	**317,017**	471,642
Business Plan Amendment	**804,022**	480,250
Other Grants	**32,486**	32,256
	24,224,336	22,415,367
Advertising	**16,940**	45,968
(Recovery) Allowance for goods and services tax receivable	**(2,847)**	7,953
Bank charges and fees	**1,860**	2,446
Catering expense	**8,541**	3,511
Contract services	**183,413**	151,372
Dues and subscriptions	**212,124**	177,202
Evaluation costs	**80,673**	81,889
Information technology	**390,369**	246,173
Insurance	**55,725**	49,339
Office and supplies	**71,868**	62,113
PAN PCN Contributions	**83,001**	93,801
Payments to physicians	**2,816,035**	2,701,810
Professional development	**102,709**	71,586
Professional fees	**49,564**	41,520
Rent	**526,803**	509,864
Repairs and maintenance	**17,805**	12,047
Small equipment purchases	**32,071**	32,882
Supported Therapy Pilot	**226,615**	9,350
Telephone and communications	**87,973**	102,990
Travel	**17,283**	9,513
Wages and benefit		
Administration	**1,894,030**	1,708,148
Clinical support	**4,094,116**	3,602,531
Health professionals	**12,940,648**	12,219,717
	23,907,319	21,943,725
Excess of revenue over expenses before other items	**317,017**	471,642
Amortization of capital assets	**(317,017)**	(471,642)
Excess of revenue over expenses for the year and net assets, end of the year	**-**	-

Expenses by Priority Initiative



Payments to Physicians

	2024	2023
	$	$
Services [1]	**97,396**	98,594
Multidisciplinary team overhead payments	**2,718,639**	2,603,216
	2,816,035	2,701,810

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

Staffing Summary

	2024		2023	
	FTE	**$**	FTE	$
Total Direct Care Provider Staffing	**105.5**	**12,940,648**	107.05	12,219,717
Total Clinical Support Staffing	**35**	**4,094,116**	34.2	3,602,531
Total Admin and Support Staffing	**17.7**	**1,894,030**	16.5	1,708,148
	158.2	**18,928,794**	157.75	17,530,396

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

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