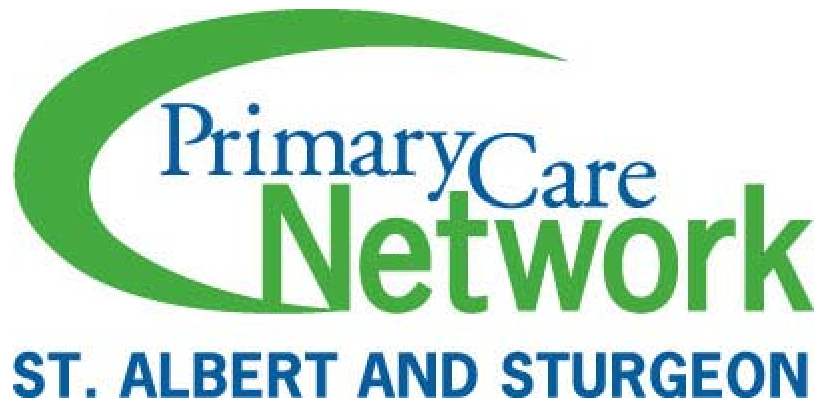

St. Albert & Sturgeon Primary Care Network

BUSINESS PLAN

April 1, 2009 to March 31, 2012

Final Version: July 27, 2009

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Summary of PCN Key Information

Name of the PCN:	**St. Albert & Sturgeon Primary Care Network**		
Geographic Area:	Alcomdale; Bon Accord; Calahoo; Gibbons; Lancaster Park; Legal; Morinville; Namao; Riviere Qui Barre; St. Albert		
Proposed Term of Plan:	April 1, 2009 to March 31, 2012	**Provincial Legal Model:**	#1

Number of:	**Clinics**	**Physicians**	**Panel # of Patients per management report from AHW of** Oct, 24, 2008	**Total Population:**
Participating in PCN	13	52		
Within PCN Geographic Area	17	59	66,073	89,663

Anticipated Health Professionals Staffing[1] (FTE) for fully implemented plan:						17.3 FTE paid by PCN
0.0	Nurse Practitioners	1.65	Dietitians	0.2	Occupational Therapists	
7.85	Registered Nurses	2.0	Pharmacists	4.6	Mental Health Coordinators	
0.0	Licensed Practical Nurses	0.0	Physical Therapists	1.0	Health Promotion Coordinator	
Anticipated Administrative Staffing (FTE) for fully implemented plan:						9.1 FTE
0.2	Evaluation	3.9	Admin Support (Assistants, Clerical)			
0.0	Medical Directorship (by Physicians)[2]	2.0	IT support (in-house and/or contracted)			
1.0	General Manager	1.0	Referral Coordinator			
1.0	Assistant Manager					
Anticipated Staffing (FTE[2]) Total for fully implemented plan:						26.4 FTE paid by PCN

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Until further notice, the PCN's Privacy Officer is:	Debbie Wilson-Makinen		

[1] Indicates staffing by credentials, allowing provincial rollup of data. Staffing by role, indicated in descriptions of Priority Initiatives (Sections 3.2, 3.3, etc.), is less accurate when rolled up due to customization to local conditions. **This excludes the service agreements we have with AHS 0.45 FTE – RN (0.2 FTE – LC; 0.25 FTE – GEM); 0.35 FTE – dietitian; 0.4 FTE – MHC**

[2] This staffing designation includes only physicians hired or contracted for substantial blocks of time (0.1 FTE or more) dedicated to medical directorships and other administrative roles. Clinical time from participating physicians (e.g., 1 hr/wk for case consultations with CDM nurses, etc.) is not included in this amount.

Executive Summary

The Primary Care Initiative Committee granted approval for the St. Albert and Sturgeon Primary Care Network (PCN) to "go live" March 1, 2006, comprising of 35 physicians. Currently, the PCN consists of 52 family physicians in 14 clinics. Of these 52 physicians, 24 physicians provide both hospital and long term care services and eleven physicians support the two Primary Care Maternity clinics, one located in St. Albert and the other in North Edmonton.

The St. Albert and Sturgeon PCN is unique in that it serves a suburban and rural population with 36% of the population residing in Sturgeon County. When compared to St. Albert and the Edmonton & surrounding area, Sturgeon County has the highest maternal prenatal smoking rate, heart disease death rate, stroke death rate and cancer death rate. Sturgeon also has a significantly higher hospitalization and emergency department visit rates than both St. Albert and the Edmonton & surrounding area. As well, there is a significantly higher teen birth rate in the Sturgeon County than in St. Albert. In light of these statistics, a satellite PCN clinic has been established in Morinville to better serve the needs of the rural population.

Specialist linkages have been established with Psychiatry and Geriatrics.

Space has been a barrier to date and surplus funding has been approved to relocate the PCN in order to accommodate the increased staff required to support physicians. An anticipated move date has been planned for March 2009.

The PCN proposes to continue to build on the existing priority areas started in the 2006 business plan. With the assistance of the Primary Health Care team (PHCT), physicians can continue to build capacity in order to manage patients within the PCN and continue to work in collaboration with Alberta Health Services (AHS) to develop processes to accept identified sub groups of unattached patients.

Key improvements to the priority initiatives contemplated in this three year plan include:

Chronic Disease Prevention & Management

Chronic disease prevention and management continues to be a priority in the renewed Business Plan. The PCN has gained valuable insight utilizing the AHS chronic disease management registry to identify and manage patients with chronic disease. This tool will enable the PCN to establish benchmarks in the area of chronic disease. The PCN will continue to provide the services of the PHCT, which consists of nurses, dietitians, pharmacists, and mental health coordinators, to support physicians in providing comprehensive primary patient care. All PCN physicians have provided consent to include their patients with Diabetes in the AHS Chronic Disease Management Registry. In collaboration with Home care, unattached palliative care patients are attached to a family physician. It is proposed this program will expand to include complex and/or chronic disease.

Health Promotion and Prevention

Health Promotion & Prevention is a new initiative within the current chronic disease and management priority. This includes initiatives such as the AHS Stop Colorectal Cancer through Prevention and Education (SCOPE) program, the AHS WeightWise Program, and the Tobacco Reduction Program. Other provincial or local initiatives will be integrated with the PCN if appropriate.

Mental Health

Physician evaluations have indicated that the Mental Health Coordinators have been instrumental in helping to bridge patients to the appropriate regional programs. This value added service for physicians will be enhanced further with future planning aimed at improving the alignment and integration of the PCN's mental health priority with regional mental health services. Three family physicians have put their names forward to support the physician shortage identified within the Regional Pediatric Developmental and Mental Health Program. The PCN will work with the St. Albert Resource Centre to ensure unattached children have a family physician.

Geriatric, Evaluation and Management

This program was established and implemented in 2007 and is an ongoing partnership between the Sturgeon Hospital, Regional Geriatric Program and the PCN. This three year business plan will continue to build on the current successes of this program and integrate further with home care.

Primary Care Maternity

From a prevention perspective, and in collaboration with the Sturgeon Community Hospital, an antenatal screening tool has been implemented that identifies mothers at high risk. In collaboration with Healthy Beginnings, a health region program that provides postpartum services, a Lactation Consultant has been integrated into the PCN. A process has been established to accept all unattached mothers and babies following delivery. A current gap exists with addressing the high rate of teen pregnancies in the Sturgeon County and the new Business Plan addresses that gap.

Access to Care

The following elements have been selected to address access to care:

Improved Access to Care

The PCN will continue to support access to one's own physician and will evaluate improved access to care by engaging physicians in an Access Improvement Measurement (AIM) collaborative that will test and deploy new strategies to improve office-based practice, clinical practice and proactive management. Research suggests that collaborative learning and improvement models fundamentally lead to increased performance levels including better patient access, enhanced office flow and efficiency. Several clinics are currently engaged in the Alberta AIM project.

In addition access is increased for those patients without family physicians with a process to attach unattached mothers and babies, unattached palliative care patients, unattached complex patients and unattached children with mental health issues. More detail is articulated in the Chronic Disease Management, Mental Health and Primary Care Maternity priorities.

Quality Improvement

A Quality Improvement Working committee has been established and will continue to oversee quality improvement projects within physician clinics and be the link for regional consultation processes such as the AHS integration project which articulates care pathways throughout the continuum of care.

Recruitment and Retention

A recruitment and retention strategy for physicians has been developed with plans for implementation in this new business plan.

Evaluation

The PCN will participate in the province wide evaluation process currently underway. In addition, the PCN is working with physicians to determine their informal enrollee lists. The PCN submits Other Health Care Providers encounters to AHW. The PCN is beginning to establish baseline measures in priority areas such as Chronic Disease Management and will capitalize on joint provincial efforts such as the Health Outcomes Indicators Project. Further detail of this is covered under section 9 of this business plan.

Other aspects of the plan where improvements are contemplated include:

Information Management

Two full time Information Management/Information Technology (IM/IT) support staff will continue to provide services to both the PCN and the physician clinics. IM/IT was a priority initiative in the original business plan, but has since been integrated across all initiatives and will be detailed in section 7, titled "Information Management."

The Governance structure implemented has worked well and remains unchanged from the previous Business Plan. It is further articulated in Section 6.

1. Overview of Local Environment

The St. Albert and Sturgeon PCN is unique in that it serves a suburban and rural population with 36% of the population residing in Sturgeon County. Specifically in St. Albert and Sturgeon County, the total population of the geographic area is approximately 89,663 (8.4% of the total region's population), an increase of approximately 6,744 from the previous 2006 Business Plan. The major population areas within the active geographic population include the following: Alcomdale, Bon Accord, Calahoo, Gibbons, Lancaster Park, Legal, Morinville, Namao, Riviere Qui Barre, and St. Albert.

Population Statistics	**Edmonton & Surrounding Area**	**St. Albert**	**Sturgeon County**	**Alberta**
Population – 2006	1,061,109	57,637	32,026	3,302,469
Demographic Information				
Average age	36.8	36.2	33.2	36.0
% 0 to 4 years of age	6.0%	5.6%	6.6%	6.3%
% 5 to 17 years of age	16.4%	18.1%	21.5%	17.5%
% 18-64 years of age	66.4%	66.2 %	63.6%	65.5%
% 65-74 years	6.0%	5.9%	5.0%	5.7%
% 75+	5.2%	4.3%	3.3%	4.9%
Federal Census Data – 2006				
% Lone parent families	16.0%	12.4%	11.4%	14.4%
% 65+ who live alone	27.9%	24.3%	18.0%	27.2%
% Aboriginals	5.0%	2.8%	7.5%	7.5%
Median Income – Census Families	$78,424	$100,540	$81,994	$76,642
Average Income – Census Families	$91,780	$113,503	$94,234	$98,240
female lone parent families average income	$46,241	$59,107	$42,598	$49,044
male lone parent families average income	$65,425	$83,372	*	$77,544
% Less than Grade 9 Education [Note]	21.6%	15.6%	25.6%	23.4%
Language – knowledge of English %	96.6%	96.9%	96.0%	97.0%
Health Statistics				
% preterm birth (live births< 37 weeks)	9.1	8.8	7.7	9.4% (2004)
Maternal prenatal smoking rate per 100 live births, 2003-2005 combined	17.7	9.5	23	19.9 (2004)
Teen Birth Rate (per 1000 women 15-19 yr)	17.2%	4.5%	13.9%	
Deaths				
Infant Mortality Rate (per 1000 live births) 2002-2006	6.4	4.8	5.8	5.8 (2004)
All Heart Disease Death Rate (per 100,000)	145.0	145.6	165.8	
Stroke death rate (per 100,000)	42.4	43.9	48.5	37.3 (2004)
Cancer Death Rate (per 100,000)	175.2	180.2	187.9	
Health Services Utilization				
Hospitalization rates, excluding obstetrics/pregnancy related (per 1,000)	63.5	58.7	80.0	
Emergency Department Visit Rate (per 1,000)	397.8	406.9	596.3	

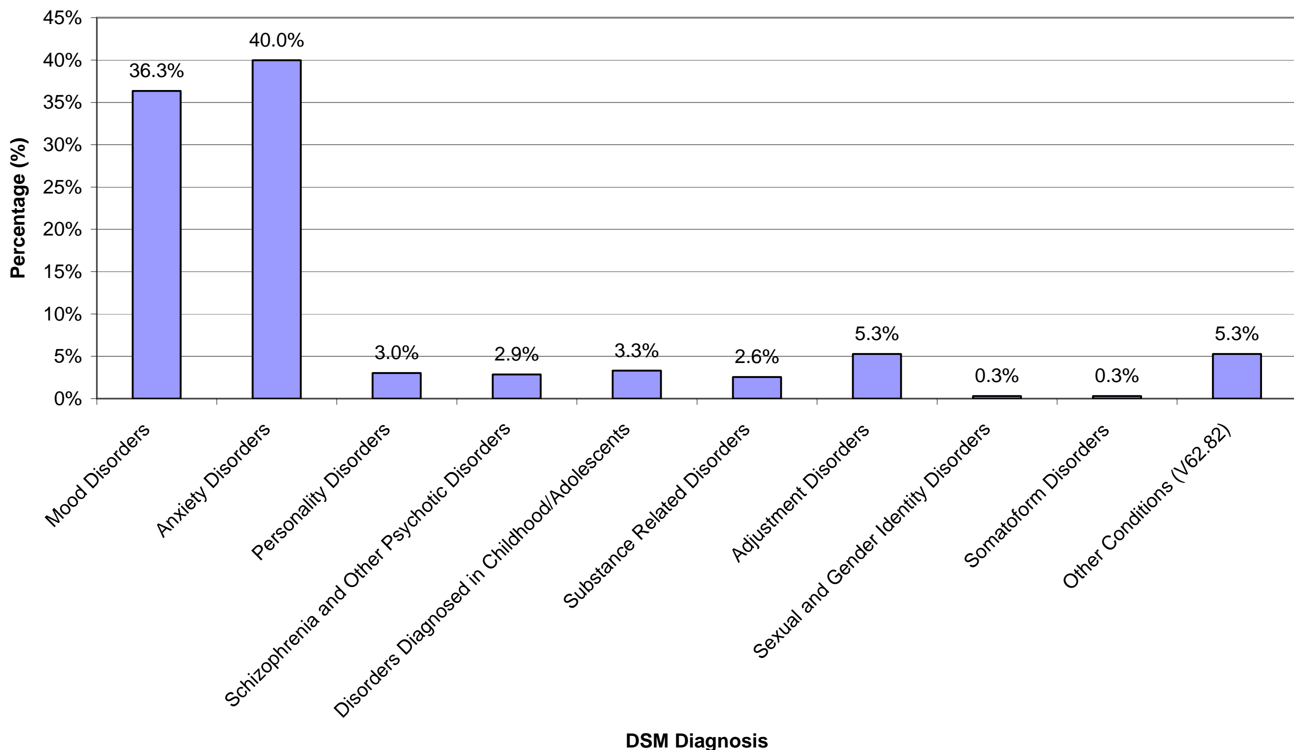
Source: Capital Health "How Healthy Are We? 2007 Annual Report of the Medical Officer of Health"
Note: The % less than Grade 9 education reflects respondents who are 15 years of age or older.
** There were insufficient numbers of male lone parents to calculate an average income.*

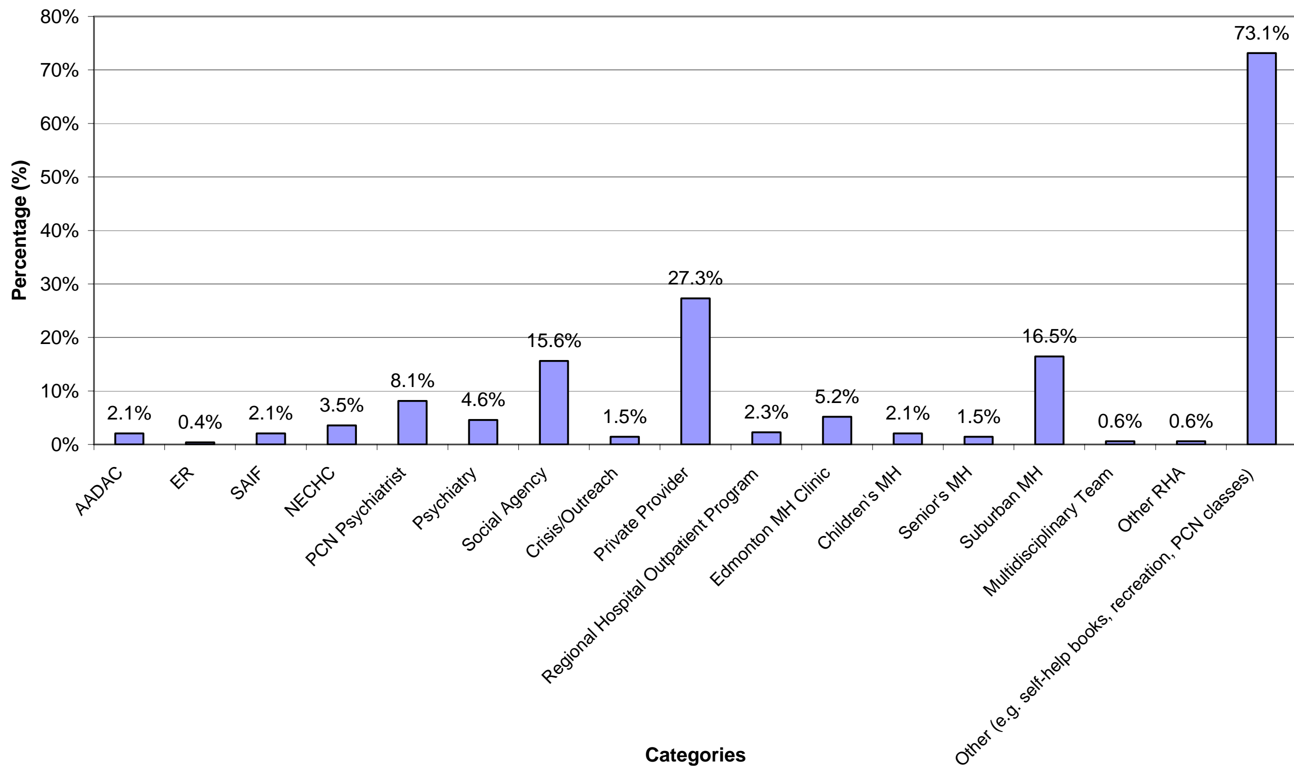
Despite their proximity, St. Albert and Sturgeon County differ significantly across a number of health indices. When compared to St. Albert and the Edmonton & surrounding area, Sturgeon County has the highest maternal prenatal smoking rate, heart disease death rate, stroke death rate and cancer death rate. Sturgeon County also has a significantly higher hospitalization and emergency department visit rate than both St. Albert and Edmonton and the surrounding area. There is a significantly higher teen birth rate in the Sturgeon County than in St. Albert. It has been noted that rural populations appear to have higher rates in certain health indices and higher utilization rates due, in part, to lack of access to services in rural communities. The PCN has established a rural PCN site to better meet the needs of their rural population.

Regarding Mental Health, it is very difficult to get information about mental health problems. In the *Health Trends in Alberta* they use some self-reported variables that are from surveys. The sample sizes do not allow for break downs to the Public Health Service areas. Many of the other mental health variables in the report are taken from physicians' claim data.

The PCN is beginning to collect information on mental health referrals from physicians' clinics. When a patient is referred to the Mental Health Coordinator, an assessment is completed by the MHC who documents a diagnosis based on the Diagnostic and Statistical Manuel of Mental Disorders (DSM) which is displayed on Graph 1. Following the diagnosis, the patient is then provided with further services which are depicted on Graph 2. The areas of focus could be more than one service required.

Previously, all crisis cases would have been referred to the Emergency Department and are now being coordinated by the family physicians, the Mental Health Coordinators and AHS regional mental health services.





Health facilities in this rural geographical area include: Sturgeon Community Hospital (SCH); two home care offices - one located on site at the SCH and another located in Morinville; two public health centers; two mental health clinics; and two continuing care centers.

The Sturgeon Community Hospital has 60 in-patient medical beds; 44 surgical beds with 5 operating room theatres; 10 coronary care beds; 5 intensive care beds; 2 child health beds; 23 beds for labor and delivery; and 15 stretchers designated for day surgery. Within the 60 in-patient medical beds, 18 beds are designated for the hospital care team which includes 10 family physicians, a nurse practitioner and a physician extender. The Sturgeon operates a 24 hour Emergency Services with full-time casualty officers providing comprehensive emergency care, including access to the Mental Health Crisis Team and Sexual Assault Response Team. There is comprehensive home care for palliative or end of life patients, which is made possible by the strong hospital affiliations with family physicians and strong consultant relationships with regional palliative and home care teams. The home care office also operates a wound care clinic seven days per week.

The Sturgeon Community Hospital has several outpatient services including the following: Intravenous Therapy Outpatient Clinic, Diabetes Education Program, Endoscopy, Outpatient Clinic, and Adult Day Program for Medical Rehabilitation and Cognitive Impairment. Current pediatric ambulatory services include: General Pediatric Visits and Consultations and a Neurodevelopment Assessment Clinic.

In collaboration with the Sturgeon Community Hospital, the Regional Geriatric Program and the St. Albert & Sturgeon PCN, a Geriatric Evaluation and Management clinic was established in 2007 and operates one day per week. In addition a Geriatric Psychiatrist is available to see both out-patients and in-patients.

Eleven PCN family physicians participate in the Primary Care Maternity clinics, which operate out of the SCH and North East Edmonton.

While municipally independent, St. Albert is significantly integrated with Edmonton. Access to Alberta Health Service regional programs in Edmonton includes access to the Tuberculosis (TB) clinic, Birth Control and Sexually Transmitted Disease (STD) clinics, and the Regional Diabetes Program and Community Rehabilitation Services through private Physiotherapy clinics. The Child/Adolescent Protection Centre at the University of Alberta Hospital is available. The Healthy Beginnings Program, operated by Alberta Health Service, is accessible in the St. Albert and Sturgeon community. Capital Health Link for triage, information, and referral is available for all St. Albert and Sturgeon community residents. Referrals to any Community Care Services programs are available to all residents 24 hours a day/7days a week by phoning Community Care Access. Home Care assessment and provision of a wide variety of services and supports are available to clients based on assessed need in a variety of settings throughout the area.

There are a total of 284 beds in two continuing care centers. Twenty four PCN family physicians currently admit and care for their own patients. Psychiatric nursing/psychiatric consulting services are available in continuing care centers upon physician request.

Current rehabilitative services in the geographical area include:

- Private services from a variety of physio and occupational therapists in the community;
- Neighborhood Chat - for Stroke survivors with aphasia;
- Audiology and speech-language programs for children;
- Home Care protocols for post hospital discharge patients following post cardiac, transurethral prostatectomy, orthopedic hip and orthopedic knee surgeries; and
- Referrals to the Glenrose Rehabilitation Hospital.

In addition to Aspenhouse and Heritage, there are several other Lodge settings in the St Albert and Sturgeon County area where a variety of client supports are provided either in-house or by the Home Care program in collaboration with a variety of operators and contracted support.

Access to respite services and special programs such as ventilation, Alzheimer's and dialysis are available.

Block funded Home Care, Personal Care Homes, Special Care Homes, Mental Health Approved Homes, and Family Care Homes are available. Designated Assisted Living spaces are being added in the community.

Alberta Alcohol and Drug Abuse Commission (AADAC) operate and funds information, prevention and treatment services to help Albertans with alcohol, other drug and gambling problems. There is a satellite office in St. Albert which provides adult and youth outpatient prevention and education programs.

St. Albert hosts a wide range of commercial enterprises delivering various types of health care. This includes (but is not limited to) pharmacies, physiotherapy, occupational therapy, podiatry, massage therapy, dentistry, laboratory, dietary consultation, diagnostic imaging, and other services. There are also numerous community organizations that are involved in health care and/or related advocacy and education. One of key roles the PCN has played to date is assisting participating physicians and their clinic staff in keeping current on "what's available where". This is important given the enormous amount of information regarding local regional and provincial programs available to support patient care within the community.

2. History, Vision, and Objectives of the PCN

The Primary Care Initiative Committee granted approval for the St. Albert and Sturgeon Primary Care Network (PCN) to "go live" March 1, 2006, which was comprised of 35 physicians. Currently, the PCN consists of 50 family physicians.

Building on the work completed within the PCN to date, the service delivery plan was developed jointly between AHS representatives and input from physicians within the PCN. Physicians participated in a survey to identify

continuing priorities and 18 physicians participated in a strategic planning retreat to discuss the future state of the PCN. Integration has been accomplished through the following service agreements with AHS:

- Service Agreement with AHS Healthy Beginnings
- Service agreement with AHS Regional Mental Health
- Service Agreement for Primary Care Maternity and the Sturgeon Community Hospital
- Service agreement with AHS Regional Chronic Disease Management Program
- Service Agreement with Sturgeon Community Hospital for the GEM clinic
- Service Agreement with AHS Regional Food and Nutrition services

These service agreements enhance collaboration and continuity of care between AHS and the PCN with the overall goal of maximizing available resource, fostering effective relationships and avoiding duplication of services.

The PCN has engaged all family physicians to participate in the AHS Chronic Disease Management Registry which has enabled the PCN to move forward in establishing a program that targets patients at risk for diabetes. In addition, the PCN has established a process to accept unattached mothers and babies. In collaboration with Home Care, a process has been established to link unattached palliative care patients with a family physician.

The PCN hopes to continue to build on the programs identified in the Business Plan and continue to support family physicians with the Primary Health Care Team (PHCT) to enable them to continue to build capacity to manage patients within the PCN and to continue to work with AHS to develop processes to accept identified sub groups of unattached patients.

The collective vision for the PCN
The St Albert and Sturgeon Primary Care Network, is a joint venture between AHS and the NPC, which is comprised of a group of Family Physicians that deliver primary care services. The PCN builds and enhances the capacity of physicians, other health professionals, diagnostic services and linkages to AHS in a collaborative environment to provide comprehensive, accessible and coordinated primary health care services to a defined population. Family physicians provide care with and through multidisciplinary teams to provide comprehensive care throughout the continuum of care.

Patient:
- Provide timely access to high quality care aimed at reducing the burden of illness and promoting health and services that is responsive to special needs and circumstances for the defined service population.

Physician:
- Quality of work life that is financially and professionally rewarding.
- All colleagues are important and all work is valued.

Other Health Professional:
- A group of proactive health professionals who are strong patient advocates working within a PCN mandate that is clear and supported by a shared understanding and mutual respect for the roles, responsibilities and contribution of all.

Definition of success for the PCN
With information and education on the prevention, diagnosis and treatment of disease, patients are active, accountable, and responsible members of the primary health care team.

In addition, success for the PCN is defined as having achieved enhanced quality of work life for PCN physicians and other health care professionals. The essential components required to achieve the

provincial objectives and serve as indicators of success include long-term sustainability of the family physician workforce. Resources are in place for other health care professionals to support coordinated and integrated access to primary care, including the infrastructure to support multidisciplinary care.

Provincial Objectives

Objective 1: To increase the proportion of residents with ready access to primary care

Objective 2: To provide coordinated 24 hour, 7-day-per-week management of access to appropriate primary care services

Objective 3: To increase the emphasis on health promotion, disease and injury prevention, care of the medically complex patient, and care of patients with chronic disease

Objective 4: To improve coordination and integration with other health care services, including secondary, tertiary, and long-term care through specialty care linkages to primary care

Objective 5: To facilitate the greater use of multidisciplinary teams to provide comprehensive primary care

Local Objectives

Objective 1: Recruitment and retention of family physicians.

This objective supports provincial objective 1 by increasing the proportion of residents with ready access to primary care.

Objective 2: Enhanced space for PCN to allow the PCN to recruit the full complement of other health care providers.

This objective supports provincial objective 5 by providing the infrastructure to recruit the full complement of other health care providers to support family physicians providing comprehensive patient care.

Objective 3: Continue to increase capacity for unattached patients

This objective supports provincial objective 1 by increasing the proportion of residents with ready access to primary care.

Objective 4: Enhanced PCN services in the Sturgeon County

This objective supports provincial objectives 3 and 5 recognizing that Sturgeon County has a higher maternal prenatal smoking rate, heart disease death rate, stroke death rate and cancer death rate in comparison to St. Albert population.

Changes to Priority Initiatives Over Time

Priority Initiatives and Elements in Original Business Plan (2005-2009)[1] **Unchanged** for Renewal (2009 – 2012)	Priority Initiatives and Elements in Original Business Plan (2005-2009) **Enhanced** for Renewal (2009 – 2012)	Priority Initiatives and Elements in Original Business Plan (2005-2009) **Discontinued** for Renewal (2009 – 2012)	**New** Priority Initiatives and Elements for Business Plan Renewal (2009-2012)
Chronic Disease Prevention and Management (Primary Health Care Team, educational programs, alignment with AHS chronic disease programs)	Chronic Disease Management - (unattached palliative care patients; group educational sessions for Heart Healthy, Live Better Every Day, Diabetes Revisited; collaboration and integration with Alexander Reserve; AHS chronic disease management registry)		Chronic Disease Management (alignment with home care to accept unattached patients with complex and/or chronic disease; referral coordinator) Chronic Disease Prevention (Obesity management, at risk for diabetes, gestational diabetes, stop colorectal cancer through prevention and education; building capacity of sport coaches)
Mental Health (Mental Health Coordinators, continued alignment and integration with AHS Mental Health, Sturgeon Community Hospital, psychiatrist specialist linkage, educational programs)	Mental Health – (enhanced integration and collaboration with St. Albert Family Resource; group educational sessions for Anxiety, Healthy Mom, Healthy Mind, Craving Change, Success Over Stress)		Mental Health Expand the mental health initiative to implement and evaluate new therapy models (self help modules and cyber counseling). Mental Health Integrate Mental Health coordinators into the Chronic Disease Prevention and Management priority (provide cognitive behavior therapy) Mental Health Recruitment of Family Physicians to support the Regional Pediatric Developmental & Mental Health Program (3 family physicians)
Geriatric Evaluation and Management (Geriatric Assessment, Evaluation and Management (GEM) Program; integration and alignment with home care; community outreach services; seniors day program; educational sessions; St. Albert mobilization committee; long-term care	Geriatric Evaluation and Management Centralized Booking System (CBS) through Health Link; Steady As You GO 2 home assessments for falls)		Geriatric Evaluation and Management (educational session for cognition and competency; further integration with AHS home care occupational therapist and pharmacist)

Priority Initiatives and Elements in Original Business Plan (2005-2009)[1] **Unchanged** for Renewal (2009 – 2012)	Priority Initiatives and Elements in Original Business Plan (2005-2009) **Enhanced** for Renewal (2009 – 2012)	Priority Initiatives and Elements in Original Business Plan (2005-2009) **Discontinued** for Renewal (2009 – 2012)	**New** Priority Initiatives and Elements for Business Plan Renewal (2009-2012)
Primary Care Maternity (Primary Care Maternity Clinic: lactation consultant)	Primary Care Maternity (unattached mothers and babies)		Primary Care Maternity (a new model entitled "centering pregnancy" for providing prenatal assessments, teen pregnancy, retention and recruitment)
			Access to Care (Access to care initiatives ; quality improvement working group; physician quality improvement; recruitment and retention; physician services provided based on point system; unattached home care patients; and evaluation[2])

[1]Information Management was a priority initiative in the original business plan, but has been integrated across all initiatives.
[2]Evaluation is under Access to Care and includes, but not limited to, maximizing collection of data through tools such as the AHS chronic disease management registry to use for benchmarks and evaluation. Evaluation is a part of each priority program and covered in Section 9.)

3. Priority Initiatives

The priority initiatives for this three year business plan expand on priorities already initiated during the first three year business plan. The priorities are:

- Chronic Disease Prevention & Management
- Mental Health
- Geriatric Evaluation & Management
- Primary Care Maternity
- Access to Care

Information Management and Technology was a priority in the original Business Plan and is the foundation of all Priority Initiatives and is discussed in further detail under section 7.

3.1. Summary of Comparative Information by Provincial Objective

PCI Provincial Objective	Priority Initiatives	Key Elements	PCI Service Responsibilities Addressed	Funding Sources and Amounts (other than per capita)
1. Increase the proportion of residents with ready access to primary care	Primary Care Maternity	• Two primary care maternity clinic sites • Recruitment and retention strategy • Unattached mothers and babies • Centering Pregnancy® Program • Lactation consultant • Teen pregnancy	(1) Basic ambulatory care (4) Prevention (5) Family planning and pregnancy counseling (6) Well-child care (7) Obstetrical care (19) Coordination with regional services (20) Unattached patients	Service Agreement with Healthy Beginnings for Lactation Consultant Sturgeon Hospital absorbs operating costs for Primary Care Maternity Clinic
	Access to Care	• Primary health care team (objective 5) • Alberta Access Improvement Measures (AIM)	(1) Basic ambulatory care (8) Palliative care (13) Primary in-patient care including hospitals and long-term care institutions	

PCI Provincial Objective	Priority Initiatives	Key Elements	PCI Service Responsibilities Addressed	Funding Sources and Amounts (other than per capita)
		• Quality improvement working group • Physician quality improvement • Unattached palliative care patients • Retention and recruitment strategy	(19) Coordination with regional services (20) Unattached patients	
2. Provide coordinated, 24-hour, 7-day-per-week management of access to appropriate primary care services	Access to Care	• Linkage with Home Care	(17) 24/7 management of access (19) Coordination with regional services (20) Unattached patients	Home care absorbs the cost of the home care nurses
3. Increase the emphasis on health promotion, disease and injury prevention, care of the medically complex patient, and care of patients with chronic disease	Geriatric Assessment, Evaluation and Management	• Centralized Booking System (via Health Link Alberta) • Assessment, evaluation and Management • Integration and alignment of Home Care • Community Out Reach • Seniors Day Program • Educational sessions • Cognition and Competency • St. Albert Mobilization Committee • Long-term care	(2) Complex care (4) Chronic screening and prevention (9) Geriatric care (10) Chronic care (14) Rehabilitative care (19) Coordination with regional Services	Alberta Health Service-Medical Affairs absorbs the remuneration costs for a care of the elderly physician 1 day per week as well as a psychiatrist specialized in managing geriatric mental health care needs Service agreement with Sturgeon Hospital
	Chronic Disease Prevention and Management	• Obesity management • At Risk for Diabetes	(4) Prevention (16) Population health	Service agreement between AHS Nutrition Services.

PCI Provincial Objective	Priority Initiatives	Key Elements	PCI Service Responsibilities Addressed	Funding Sources and Amounts (other than per capita)
		• Gestational Diabetes • Stop Colorectal Cancer through Prevention and Education • Building capacity of Sport Coaches to Deliver Tobacco Reduction Education to Young Athletes		
4. Improve coordination and integration with other health care services including secondary, tertiary, and long-term care through specialty care linkages to primary care	Mental Health Geriatric Assessment, Evaluation and Management Chronic Disease Prevention and Management Primary Care Maternity	• Family physicians with hospital privileges • Family physicians with long-term care privileges • Specialist linkage with psychiatrist • Care of the elderly physician	(19) Coordination with regional services (20) Unattached patients	
5. Facilitate the greater use of multidisciplinary teams to provide comprehensive care	Mental Health	• Mental Health coordinators • Recruitment of Family Physicians to support the Regional Pediatric Developmental & Mental Health Program • Alignment with St. Albert Family Resource Centre • Chronic Disease	(3) Psychological Counseling (19) Coordination with regional services (20) Unattached patients	Service agreement between AHS Mental Health to enhance linkages. Through specialist linkages fund, the psychiatrist is paid via one of the following methods by the PCN when he submits an invoice.

PCI Provincial Objective	Priority Initiatives	Key Elements	PCI Service Responsibilities Addressed	Funding Sources and Amounts (other than per capita)
		Regional Mental Health • Alignment with Sturgeon Community Hospital • Specialist Linkages • Educational Sessions • Self help modules		$35 administrative fee for consultations with other health care professionals regarding the patient and for work he can not bill through FFS. 2. For patients that he is booked for **but do not show up for the appointment,** the psychiatrist is paid $222 per hour guaranteed minimum rate, for a no-show fee to help compensate for part of the FFS he could have gotten if the patient did show up. 3. The psychiatrists payments from the PCN are to cover costs not claimable through any other means, e.g. Fee for Service.
	Chronic Disease Prevention and Management	• Primary Health Care Team • Collaboration and integration with Alexander Reserve	(2) Complex care (4) Chronic Screening and Prevention (9) Geriatric Care (10) Chronic Care (15) Information	Alberta Health Service agreement to maintain patient lists on Chronic Disease Management Disease Registry

PCI Provincial Objective	Priority Initiatives	Key Elements	PCI Service Responsibilities Addressed	Funding Sources and Amounts (other than per capita)
		• Alignment with home care and unattached palliative care patients • Alignment with home care and unattached patients with complex and/or chronic disease • Alignment with Regional Chronic Disease Programs • Referral Coordinator • Educational sessions • Self help Modules	Management (16) Population Health (19) Coordination with Regional Services (20) Unattached patients	

3.2. Priority Initiative: Chronic Disease Prevention & Management

Chronic Disease Prevention and Management continue to be an ongoing priority due to the increasing prevalence and incidence of chronic disease. Albertans living with multiple co-morbidities face considerable challenge in navigating the heath care system to successfully meet their health needs. Working in collaboration with AHS and integrating the AHS registry for chronic disease, the PCN is able to identify and proactively target patients with chronic disease and begin to support family physicians in managing this group of patients. Building on the success to date with the utilization of the PHCT, it is anticipated this priority will continue to shift physician emphasis from episodic care to more comprehensive, coordinated care.

The service gaps the objectives of this specific initiative are intended to address are:

- Physicians do not have an infrastructure in place to clearly identify the patient population they serve. The AHS Chronic Disease Management Registry along with the physician's informal enrollee list is a beginning step and identifies the patients within their practice allowing the PCN to make informed decisions with respect to program planning and allocation of resources.
- Home care has unattached complex and/or chronic care patients within the PCN jurisdiction and find it very time consuming to try to attach a patient to a family physician when they no longer can support the patient care needs on their own and require treatment interventions that require a physician order to implement.
- Previous Business Plan was limited in its focus on Health Promotion and Prevention

Objectives:

- Build on the work completed to date with the Chronic Disease Management Registry and the Primary Health Care Team in addressing the prevention and management of chronic disease within the St. Albert & Sturgeon community
- In collaboration with home care and the Primary Heath Care Team, attach palliative care patients and patients with complex/chronic disease with no family physician
- Enhance support to individual patients to increase their capacity for self-management by providing education and tools to support self-management
- Continue to engage physicians in demonstrating tangible value of all members of the Primary Health Care Team by developing practice models that promote all health care providers to work to their full scope of practice
- Continue to establish strong coordinated referral processes within AHS

The target populations this specific priority initiative will aim to serve are:

- Patients within the physician's informal enrollee list and the AHS Chronic Disease Management Registry, including newly diagnosed diabetic patients
- Unattached palliative care patients attached to home care will be attached to a family physician by the PCN
- Unattached complex/chronic disease patients receiving home care will be attached to a family physician by the PCN
- In collaboration with AHS, establish a comprehensive program to treat overweight and obese patients
- To prevent or delay the onset of Diabetes in the at risk group identified through the Chronic Disease Management Registry

- To establish a process to monitor women who have been diagnosed with gestational diabetes
- In collaboration with AHS, establish a screening process in physicians offices for colorectal screening
- To increase awareness of the harmful effects of smokeless tobacco
- Patients with a Body Mass Index > than 40
- Patients at risk for diabetes identified through the Chronic Disease Management Registry
- Patients diagnosed with gestational diabetes in the Primary Care Maternity clinic
- Patients between 50-75 who are eligible for colonoscopy screening
- Organized sport coaches who coach children between the ages of 12-18 years of age

Element	**Description**	**Resource Requirements**
Primary Health Care Team (PHCT)	**Key roles and responsibilities include:** • Under the supervision of family physicians, the Primary Health Care team will continue to build on the work in supporting family physicians to manage patients with chronic diseases. The goal is to have 100% of the PCN population identified, categorized and assigned to appropriate services with follow up. Target patient populations include diabetes, cardiovascular disease risk; COPD/asthma and cancer follow up. • Each family physician clinic will be assigned a team of health care professionals. • Enhance a comprehensive approach to treat chronic diseases listed above by integrating with current regional support programs and clearly defining roles of the Primary Health Care Team. This will include a pre-assessment to determine the appropriate team members involved and services required (i.e. individual and group sessions). • Build on and integrate the work completed by AHS on protocols and shared care paths to support seamless transition of patient discharges from hospital back to community. • Support family physicians with anticoagulation monitoring. • Track, monitor and provide feedback to the Primary Care Network in order to measure outcomes to inform future service recommendations. This will encompass the number of PCN patients listed on the registry for chronic conditions, the number	Primary Health Care Team (PHCT) for the three year business plan is comprised of: • 2 FTE Dietitians • 2 FTE Pharmacists • 6 FTE CDM nurses • 1 FTE Health Promotion and Prevention coordinator

	of PCN physicians participating in patient registries for chronic conditions and the percentage of physicians utilizing patient registries for chronic conditions. The percentage of complex patients managed by the Primary Health Care Team will be tracked. The PCN will work in collaboration with regional and provincial organizations as indicators are identified and establish the infrastructure to collect the required information.
	
	• Partnership established with the Department of Health Promotion Studies University of Alberta to consult on program planning for patients with diabetes and patients at risk for diabetes.
	
	Educational sessions
	
	• Classes are offered through physician or by self-referral. Evaluation of class occurs at the end of each session and improvements are made accordingly.
	
	<u>Classes include:</u>
	• Heart Healthy
	    o An educational session for patients who have been diagnosed with dyslipidemia.
	    o Topics covered include: healthy eating, active living, physical activity, medication and knowing risks of heart disease.
	• Live Better Every Day
	    o An interactive educational session that increases patient's ability to manage their chronic condition. Topics include managing symptoms, making action plans, working with the health care team, dealing with stress, relaxation and increased exercise, activity and healthy eating.
	• Craving Change
	    o An educational group designed to target binge-type eating behavior. It introduces cognitive behavioral techniques that can be utilized to improve emotional regulation and eating behavior. Participants will gain self-awareness and new strategies to manage eating behaviors in relation to emotions.
	• Diabetes Revisited	

- An interactive series of 6 sessions focusing on the challenges of living with diabetes for those who have had the disease for 2 or more years and have had previous diabetes education. Information presented includes diabetes and chronic disease self management, goal setting, problem solving, nutrition beyond the basics, medication, foot care, depression and activity. The last session will include a Q and A period with a panel of experts.

Obesity Management

- Establish a comprehensive approach to treat overweight and obese patients through a multidisciplinary coordinated care model.
- Alberta Health Service's Weight Wise Program offers a range of bariatric services for adults and children. These services include: lifestyle counseling/education, bariatric diagnostics, psychological counseling, medical and nutritional management, and surgical care To better address the needs of individuals with obesity, the Alberta Health Service's WeightWise program and the St Albert & Sturgeon Primary Care Network will collaborate and integrate in the following ways:
  - Share standardized obesity care guidelines / treatment algorithms, as well as other obesity-related management tools
  - Provide PCN staff training in obesity management from a multidisciplinary perspective
  - Offer consultation (i.e. case conferences) with AHS weight wise program staff to enable more timely and optimal management of patients by PCN clinicians/multidisciplinary team
  - Share WeightWise Education Modules, which can be delivered by PCN staff and/or offered to patients in venues more conveniently located via Telehealth
  - Provide Weight Wise Adult Weight Management Clinic Orientation to appropriate patients. This could be offered by the PCN as a means of determining if the specialty clinic is a good option for PCN patients.
  - Offer multidisciplinary support (medical, nursing, nutritional, behavior modification, rehabilitation) for

<table>
<tr><td></td><td>ongoing management of patients, especially those discharged from the WeightWise program.

At Risk for Diabetes

• Based on the Chronic Disease Management Registry, a high-risk sub group has been identified which consist of patients who have an impaired fasting glucose and at high risk of developing diabetes in the future
• In collaboration with AHS Food and Nutrition, AHS Weight Wise and the Department of Health Promotion at the University of Alberta , develop and implement a program to delay or prevent the onset of Type 2 diabetes

Gestational Diabetes

• Identify women through the Primary Care Maternity Clinic who have been diagnosed with gestational diabetes and ensure follow-up and counseling (as required) to the women and their children</td><td></td></tr>
<tr><td>Collaboration and integration with Alexander Reserve</td><td>• Establish better communication mechanisms between the Alexander Reserve and the Primary Health Care team. Following Screening of Limbs, Eyes, Cardiovascular and Kidneys (SLICK) assessments by the nurse on the reserve, the CDM nurse completes any necessary follow up.</td><td>PHCT</td></tr>
<tr><td>Alignment with home care and unattached palliative care patients

Alignment with home care and unattached patients with complex and/or chronic disease</td><td>• In collaboration with home care, unattached palliative care patients are assigned to a family physician.
• In collaboration with home care, unattached patients with complex/and /or chronic disease patients are assigned to a family physician.
• This could include patients where the family physician has retired and no family physician has been recruited.</td><td></td></tr>
<tr><td>Alignment with AHS Chronic Disease Programs</td><td>• Reduces the workload of each health care provider when the sharing of information and services occurs;
• Improves efficiency and access to care by identifying priority needs.
    o Work with Family Physicians in the community, other health professionals and local and regional programming to ensure programs are developed on</td><td>PHCT and Alberta Health Services</td></tr>
</table>

	the best available information • The following programs are integrated with this PCN and this partnership helps prevent duplication of services and increases the number of community resources available to patients. There are strong linkages with the following regional programs to date: o Regional Diabetes Program o Regional Weight Wise Program o Live Better Every Day o Life Skills for Kids (Pediatric Weight Management) o Home Care	
Referral Coordinator	▪ A referral coordinator will be recruited to support family physicians with referrals to Specialists beginning with Orthopedics.	
Self Help Modules	• Explore self help learning modules on line for patients such as the not for profit Climate program sponsored by St. Vincent™ Hospital, Sydney.	• PHCT • Complete a Part B PIA
Stop Colorectal Cancer through Prevention and Education (SCOPE)	• Establish registry and partner with the SCOPE Program for Colonoscopy screening • Establish mechanisms to ensure streamline access to tertiary centre	• 1 FTE administrative support to complete baseline data collection for this and ongoing projects • PCN Health Promotion and Prevention Coordinator
Building capacity of sport coaches to deliver tobacco reduction education to young athletes	• Continue to collaborate with Alberta Health Services- Alberta Alcohol and Drug Abuse Commission(AADAC) on building coaches' capacity to deliver tobacco reduction strategies	• Grant from Alberta Health Services AADAC

Risks & Mitigating Activities Associated with Chronic Disease Prevention & Management Priority Initiative

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
• Patient volumes overwhelming program resources	• Collaborate with regional programming to avoid duplication and ensure the integration and maximization of all available resources • One to one counseling of patients with the same health issue is very time consuming. The PCN is increasing access and maximizing PCN clinical staff resources by having more group sessions for certain health conditions such as the Heart Healthy class for patients diagnosed with dyslipidemia • Monitor wait lists to inform decision making with respect to potential realignment of resources	• Provide the PCN Board with information to enable informed decision making with potential realignment of resources
• Current PCN patients becoming unattached because of physicians retiring	• Retention and Recruitment strategy • PHCT practicing to their full scope of practice • AIM	• Nurse Practitioners
• Uncertainty with Information Technology and ability to develop registries and identify informal enrollees with current EMRs	• Work in collaboration with key stakeholders to provide information to physicians to support informed choices on future vendor selections	• Maximize available support through provincial programs • Support transfer of patient information to new EMRs and Registries
• Access to primary care takes precedence over quality where physician with very high numbers of informal enrollees are not fully engaged with the primary health care team	• Continue to work with physicians to demonstrate tangible value of other health care providers • Work with physicians champions who are willing to support the pharmacist to work to their full scope of practice by prescribing for specific patients within chronic disease • Promote a culture of quality improvement by supporting practice audits and providing physicians with feedback • Quality Improvement Working Committee provides leadership to the general membership on opportunities for improvement	• The PCN will engage physicians who choose to be leaders and champions

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Lack of physician support to access informal enrollee lists for use in establishing a baseline data for purposes of evaluation	• Assist with identification of informal enrollee list by physician • Ensure strict enforcement of privacy policy by limiting access to information and working with clinic staff when possible • Consider joint initiatives to provide population health screening and follow-up	• Collaborate with physicians who are prepared to engage in the Stop Colorectal Cancer through Prevention and Education (SCOPE) project
Lack of resources with which to measure success with Obesity Program and program for At Risk Group	• Maximize resources from AHS Regional programs such as AHS weight wise program and AHS food and nutrition programs • Establish a small number of baseline targets and monitor progress • Continue to work with the Department of Health Promotion at the University of Alberta who has established grants to support data collection and analysis	• Carry over resources from 2008/2009 to support evaluation and measurement

3.3. Priority Initiative: Mental Health

Mental Health continues to be a priority in this PCN with the Mental Health Coordinators role evolving to include both navigation of patients and short term therapy. Physician evaluations strongly support the continuation of this role, with continued integration of AHS Mental Health to ensure continuity of care.

The service gaps the objectives of this specific initiative are intended to address are:

- While the Mental Health Coordinators have played a significant role in supporting family physicians by coordinating referrals to appropriate mental health services, a gap continues to exist with access to mental health therapy

Objectives:

- Continue to support family physicians with the navigation of patients through the health care system
- In collaboration with AHS Mental Health and the Primary Care Network, review process to better integrate and align available resources by defining overlaps, differences and context of services and expectations
- In collaboration with AHS Mental Health, explore options for integrated care tracking mechanisms
- Implement and evaluate self help modules for depression and anxiety
- Implement and evaluate "Cyber Therapy", a web-based tool with therapy modules which provides an alternative mode of service delivery for patients

The target populations this specific priority initiative will aim to serve are:

- Referrals from family physicians
- Unattached children with potential mental health issues that require a family physician to gain access to regional programs for assessment

Element	Description	Resource Requirements
Mental Health Coordinators	**Key roles and responsibilities include:** • Facilitate the care of adult and pediatric patients by coordinating referrals to appropriate mental health services/programs and supporting this care with appropriate follow-up • Provide short term therapy and bridge patients referred to regional mental health services • Set-up, track, monitor and provide feedback to the Primary Care Network in order to measure outcomes to inform future service recommendations. Refer to Appendix B.	Budget Allocations for the three-year business plan:

Recruitment of Family Physicians to support the Regional Pediatric Developmental & Mental Health Program	• Due to a shortage of specialists, the neurodevelopment clinic has requested support in assessments in the Regional Pediatric Developmental & Mental Health Program. Three family physicians have indicated interest to be trained with this special skill set	
Alignment with St. Albert Family Resource Centre	• In order to access the Regional Pediatric Developmental & Mental Health Program, the patient must have a family physician. The PCN will work with the St. Albert Family Resource Centre when an unattached child requires an assessment and potential referral to the Regional Pediatric Developmental & Mental Health Program	The Mental Health Coordinator will be the first point of contact for the St. Albert Family Resource Centre – no financial impact to PCN
Chronic Disease Management	• Provide support to Primary Health Care Team by facilitating Cognitive Behavioral Therapy for patients within the Chronic Disease Prevention and Management Program	PHCT and Mental Health Coordinator
Alignment and integration with AHS Mental Health	• PCN staff to facilitate the completion of assessments for regional mental health patients when the patient is referred to the clinic • Improve efficiency and access to care by identifying priority needs and establish case conferencing • Primary Care Mental Health Working Committee oversees the integration and coordination of programs and service delivery in St. Albert and Sturgeon County	1 FTE MHC
Alignment with Sturgeon Community Hospital	• Provide linkage and bridge patients between hospitals and community services.	1 FTE funded by Sturgeon Community Hospital
Specialist Linkage	• In collaboration with the family physician and psychiatrist, support the ongoing management of patients with mental health diagnosis and treatment recommendations	Psychiatrist available 2 afternoons a month
Educational sessions	• Classes are offered through physician or by self referral. Evaluation of class occurs at the end of each session and improvements are made accordingly Healthy Minds, Healthy Moms • A support group for expecting and post partum moms experiencing depression or anxiety • Groups are co-facilitated by health professionals from Alberta Health Service and the St. Albert and Sturgeon Primary Care Network • Topics covered include: relaxation skills, coping with anxiety, relationship issues, wellness, medications, self-care, exercise, nutrition and anger management Craving Change	Program offered jointly between PCN and Regional Mental Health PCN Program

	• An educational session that discusses why you eat the way you do Anxiety Education Group • An educational session to learn coping strategies and techniques to help take the fear out of anxiety disorders Success Over Stress • Groups are co-facilitated by health professionals from Alberta Health Services and the St. Albert and Sturgeon Primary Care Network • An interactive session for stress management that covers : self awareness as it relates to managing stress, achieving balance to cope with life/daily hassles, ways to maintain control over stress	PCN Program – costs covered under the materials costs Program offered jointly between PCN and Regional Occupational Therapy – no financial impact to PCN
Self Help Modules	• Implement and evaluate self-help learning modules on line for patients for depression and anxiety • Implement and evaluate Cyber Therapy	• 1 FTE MHC • Part B PIA

Risks & Mitigating Activities Associated with Mental Health Priority Initiative

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Patient volumes overwhelming program resources	• Utilization of self help modules will maximize therapist time by having appropriate patients utilizing the self help modules thereby decreasing need for direct intervention by a therapist • Review current intake process for Regional Mental Health and PCN to ensure duplication is not occurring and explore further opportunities for collaboration and integration	• Adjust plan and resources as necessary
Physicians no longer able to participate in Regional Pediatric Developmental & Mental Health Program	• The PCN has surveyed the physicians and identified 3 physicians agreeable to take additional training to be able to provide services within the Regional Pediatric Developmental & Mental Health Program • Work with AHS to identify payment gaps created and move forward with an alternative payment plan	• As a contingency, develop an alternative service delivery model
Treatment for patients may become disjointed because there is an intake process for mental health services through the PCN and the Regional Mental Health. Patients can also access mental health services through the Sturgeon Community Emergency department or as an inpatient	• In order to better service the mental health community, a more comprehensive effort in joint planning is required by all parties involved including but not limited to the Sturgeon Community Hospital, St. Albert & Sturgeon PCN and the suburban Regional Mental Health Program • Utilizing the existing PCN Mental Health Working Group develop appropriate guidelines and other tools to improve service delivery	• Centralize the intake process for suburban Regional Mental Health and the PCN

3.4. Priority Initiative: Geriatric Evaluation & Management

In collaboration with the AHS Geriatric Program, Sturgeon Community Hospital and the PCN, a program was established in the previous Business Plan to support family physicians providing care to an elderly population. This program continues to meet the needs of family physicians by providing access to a geriatrician to complete comprehensive assessments. The role of the nurse has evolved from doing assessments to being a case manager for this complex group of patients. Given the aging population there will be a continued need for a dedicated program to provide timely access for geriatric assessments, evaluation and management.

The service gaps the objectives of this specific initiative are intended to address are:

- The Geriatric, Evaluation and Management Program were established as a result of a gap identified to meet the needs of an aging population. The program was developed in collaboration with the AHS Geriatric Program, the Sturgeon Community Hospital and the PCN. The majority of referrals from family physicians are home care patients. Further integration needs to occur with home care.

Objectives:

- To continue to support family physicians in providing comprehensive geriatric assessments
- To continue to enhance the collaboration and integration of home care with the Geriatric Program

The target populations this specific priority initiative will aim to serve are:

Population Statistics	St. Albert	Sturgeon
% 65-74 years	5.9%	5.0%
% 75+	4.3%	3.3%

Element	Description	Resource Requirements
Centralized Booking System (CBS) through Health Link	• Centralized system at Health Link facilitates collaboration and communication between 8 regional geriatric sites • System increases efficiencies for scheduling and tracking of geriatric patients • Scheduling occurs in a centralized outpatient clinic • Triage nurse prioritizes and triages patients according to regional criteria and urgent or non-urgent status; and then scheduling clerks schedule patients for their assessments	
Geriatric Assessment, Evaluation and Management (GEM) Program	• Ongoing partnerships between Sturgeon Community Hospital, regional Geriatric Program and the PCN • Clinic operates Monday to Friday at Sturgeon Community Hospital • Geriatrician provides comprehensive geriatric assessment of patients in a weekly clinic; • RN in Clinic provides comprehensive geriatric assessment to assist seniors over 65 yrs remain as optimally independent as possible; patients < 65 years assessed on an individual basis.	Budget Allocations for the three-year business plan:

	• Geriatric psychiatry is available for out patients. • Linkages exist with Regional programs such as Coping for Caring, Boosting Your Memory, Steady As You Go • Linkages exist with Community Rehabilitation Programs	
Integration and Alignment with Home Care (AHC)	• Referral to Home Care Occupational Therapist for cognition tests such as cognistat or EXIT exam and Steady As You Go 2 • Pharmacist provides services such as structured medication reviews for geriatric patients or for polypharmacy • Continue to work with home care and coordinate physicians with home care nurses with regular scheduled meetings	• Service agreement still to be negotiated with AHS Home Care for a 0.2 FTE occupational therapist to assist the GEM clinic. • 0.2 FTE for pharmacist support.
Community Outreach Services	• Linkages with community outreach services including legal, housing, counseling, finances, transportation, personal care, equipment, abuse, special needs, etc • Outreach Services are available for those who do not fall under the Home Care mandate through St. Albert Seniors Coordinator	
Seniors Day Program	• Follow-up of patients in GEM clinic • GEM RN to participate in patient case conferences as needed in day program • Geriatrician to provide specialized assessment of care to patients in Seniors' Day Program as need occurs.	
Educational sessions	A GEM nurse in collaboration with AHS provides the following educational sessions: HEALTHY AGING • Educational session that discusses natural aging processes, dispels myths about aging, provides practical healthy eating & exercise tips and describes memory loss • Classes are offered through physician or by self referral. SAYGO 1 • AHS program for seniors to reduce their risks for falling SAYGO 2 • Session acts as a guide for seniors with limitations to energy or mobility to reduce their risks for falling • Geriatric nurse refers each senior to RHA PT/OT or to CSA physiotherapy appropriately depending on patient's needs BOOSTING YOUR MEMORY (BYM) • A memory enhancement program for adults over 50 years without dementia or Alzheimer's disease: o strategies are provided to assist with enhance memory skills	

Cognition and Competency	• Geriatric nurse facilitates a 2 hr educational session for seniors and their caregivers/ partners in partnership and collaboration with the HC SW, geriatrician and public guardian office. • Each session will be offered to public two to three times yearly commencing fall 2009; frequency of sessions and location in hospital to be determined.	• GEM nurse
St Albert Mobilization Committee	• Purpose is to explore, discuss and evaluate challenges of seniors in community such as transportation • St. Albert Seniors working group helps to plan and deliver strategies that address seniors needs and challenges in the community • Members share information about their work with seniors • Promotion of GEM Clinic to committee	• GEM nurse linked to committee
Long Term Care	• NP to support family physicians providing patient care in Long Term Care at the Citadel and Youville	• NP

Risks & Mitigating Activities Associated with Geriatric Evaluation & Management Priority Initiative

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Patient volumes may overwhelm program resources	• Ensure a better alignment and integration of resources with home care to minimize resource duplications • Monitor wait times on an ongoing basis to assess utilization level	• As required, obtain additional support from the Primary Health Care Team

3.5. Priority Initiative: Primary Care Maternity

This priority initiative has provided tangible value to the PCN and the residents of St. Albert, Sturgeon County and North Edmonton. Eleven family physicians provide Primary Care Maternity and are dedicated and committed to women in need of managed maternity care. The volume and demand for this program has increased with expectations that the trend will continue.

An evaluation of this program suggested the continuation of the lactation consultant role and the screening tool implemented to identify women at risk for poor postnatal psychological outcomes.

The service gaps the objectives of this specific initiative are intended to address are:

- Many physicians do not practice Primary Care Maternity

Objectives:

- To provide Primary Care Maternity supporting PCN physicians who do not provide low risk obstetrical deliveries
- To provide access to patients who do not have a family physician
- To attach mom and baby to a family physician following delivery
- To complete a screening tool designed to identify antenatal psychological risk factors for poor postnatal psychological outcomes. The tool incorporates 15 risk factors associated with woman abuse, child abuse, post partum depression and couple dysfunction
- Appropriate referrals and follow up are completed by the Primary Health Care Team and Lactation Consultant.

The target populations this specific priority initiative will aim to serve are:

- Women within the St. Albert, Sturgeon County and north Edmonton who have a family physician that does not practice Primary Care Maternity or women who do not have a family physician.

Element	Description	Resource Requirements
Primary Care Maternity Clinic	• Primary Care Maternity (PCM) clinics offer prenatal and postnatal obstetrical patients care . Eleven family physicians practice primary care maternity. There is a clinic in the Sturgeon Community Hospital and a clinic located in north Edmonton to serve this high needs population. • PCM physicians accept patients from family physicians who do not have hospital privileges and obstetrical patients who do not have family physicians. • The Antenatal Psychological Health Assessments (ALPHA), a screening tool, completed within the PCM clinic, presents a series of suggested questions designed to identify antenatal psychological risk factors for poor postnatal psychological outcomes. The patient is then referred to one of the members of the Primary Health Care Team or referred to appropriate community agencies.	• Dedicated permanent space. o Cost of the space is currently absorbed by the Sturgeon Community Hospital o The PCM clinic in north Edmonton will be relocated in April 2009. The new space has no lease costs to the PCN due to negotiated arrangements with AHS – Community Health Services

Recruitment and retention strategy	• Develop a recruitment and retention strategy to engage Edmonton North PCN family physicians to participate in the Primary Care Maternity Clinic in North East Edmonton. • Collaborate with the Edmonton North PCN to refer patients in that geographical area when the patient's ALPHA tool indicates intervention. • Explore the option of recruiting a midwife to join the Primary Care Maternity Clinic • Encourage family physicians in other PCNs to accept unattached mothers and babies within their geographical boundaries	
Unattached mothers and babies	• Data was collected from May 28, 2007 to November 26, 2007 to determine the number of women who do not have family physicians. Approximately 30% of women did not have a family physician creating a gap in the discharge process with lack of appropriate follow up in the community. • Currently all patients that have their care provided by the Primary Care Maternity Clinic are attached to a family physician following delivery if they do not have a family physician • A process has been established to attach mothers and babies that do not have a family physicians and are delivered by a specialist • A process has been established with Healthy Beginnings to attach mothers and babies who deliver at the other acute care hospitals in Edmonton but reside in St. Albert and Sturgeon Community.	
Implement a new model entitled "centering pregnancy" for providing prenatal assessments	• In collaboration with the Sturgeon Community Hospital implement a new **CenteringPregnancy® Program.** This program will replace the current traditional model providing prenatal care. • This program alters routine prenatal care by bringing women out of exam rooms and into groups for their care. The groups form between 12 and 16 weeks of pregnancy and continue through the early postpartum period meeting every month for the first four months and then bi-weekly. • As women come to the group they engage in the self-care activities of weight and blood pressure checks, estimation of gestation age and recording on their chart.	
Lactation Consultant	**Key roles and responsibilities include:** • Link Healthy Beginnings and Primary Care Network physicians and serve as a resource person to Primary Care Network physicians. • Implement a health promotion tool in the Primary Care Maternity Clinic (Alpha tool). • Oversee the process to attach mother and babies in the Primary Care Maternity clinic. • Assess patients in the Primary Care Maternity Clinic at 36 weeks to identify high risk for breastfeeding problems and to follow up following hospital discharge.	

	• Provide breastfeeding assessments, support, and counseling to Primary Care Network patients. • Provide leadership for activities to promote breastfeeding in the community. • Track, monitor and provide feedback to the Primary Care Network in order to measure outcomes to inform future service recommendations	
Teen Pregnancy	• There is a high rate of teen pregnancies in the Sturgeon County. In collaboration with Community Health Services, it is proposed that strategies be aimed at this target group to decrease the rate of teen pregnancies	• PCN Health Promotion and Prevention Coordinator and Community Health Services

Risks & Mitigating Activities Associated with Primary Care Maternity Priority Initiative

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Inability to recruit physicians to practice Primary Care Maternity	• Implement the Centering Pregnancy model that maximizes resources by providing care within a group model	• Develop recruitment and retention strategies to engage more family physicians to practice primary care maternity • Request that PCIC develop policies for rules of engagement with midwives as CORE providers within a PCN • Close the clinic in Edmonton North and operate 1 PCM clinic in St. Albert
Limited capacity of St. Albert and Sturgeon PCN family physicians to continue to accept all unattached mothers and babies	• Continue to build relationships with the Edmonton North PCN to increase awareness of this specific group of patients	• Continue to provide the service during the 2009-2011 year and begin to engage the support of other PCNs to develop their program for attaching patients within their geographical boundaries.
Sturgeon Community Hospital unable to financially continue to support two PCM clinics	• Engage Edmonton North PCN to contribute financially to support PCM clinic in their jurisdiction • Lobby the City of Edmonton and the City of St. Albert to increase bus transportation allowing women in the Edmonton North to access the St. Albert Primary Care Maternity Clinic	• Close the clinic in Edmonton North and operate 1 PCM clinic residing in St. Albert

3.6. Priority Initiative: Access to Care

This is a new initiative to begin to support family physicians to improve clinical care in primary care through access to and continuity with one's own family physician. The PCN has worked to develop a trusting relationship with physicians and success has been demonstrated by 100% of physicians providing consent to enroll their patients in the AHS chronic disease registry and 100% of clinical staff having access to the patient's electronic record. Initiatives need to be fostered to continue to work with physicians in the area of quality improvement.

The service gaps the objectives of this specific initiative are intended to address are:

- Limited capacity for physicians to accept unattached patients
- No processes currently exist to support family physicians in quality improvement initiatives. To create a system that delivers exceptional clinical care, a practice must use an improvement process. The improvement process helps those involved understand current practice and obtain information to guide decisions, and provides a compass for directing the practice towards high quality healthcare
- Limitations exist in the infrastructure to collect baseline information for evaluation

Objectives:

- Support physicians accepting unattached patients by having the PHCT complete initial assessments
- Support and develop physician leadership in the area of quality improvement by coaching and providing opportunities to attend workshops related to quality improvement processes
- Support family physicians in quality improvement processes by completing practice audits for physicians when requested. Main Pro C and/ or Main Pro 1 credits will be mandated by the College of Physicians and Surgeon by December 2009 and practice audits can be submitted to the College for credits.
- Capitalize on opportunities such as AIM by sharing information on learning sessions with other PCN physicians
- Improve clinical care in primary care through access to and continuity with one's family physician and their teams

The target populations this specific priority initiative will aim to serve are:

- Primary Care Network physicians and their teams

Element	Description	Resource Requirements
Access to Care	• Monitor improvements through access to and continuity with one's own family physician utilizing the planning and operational reports from AHW • Continue to support physicians participating in AIM by assisting with data collection and coaching • Share successes and lessons learned providing facilitator support to clinics • Offsetting partial costs to participants	

	• Measure access to care for the purpose of improvement	
Quality Improvement Working Group	**Key roles and responsibilities include:** • The working group will advise the General Manager and Board on the development of a quality improvement and risk management strategy for the PCN. • The working group will communicate with the general membership on projects and opportunities related to quality improvement initiatives. • The working group ensures liaison with other health system initiatives, including but not limited to the Health Outcomes Initiative, Toward Optimized Program, Primary Care Initiative Program; Chronic Disease Management registry project; and the Do Bugs Need Drugs Program. • The St Albert and Sturgeon Primary Care Network Quality Improvement Working Group is accountable to the PCN Board of Directors. Members of the working group will provide advice and recommendations to the General Manager on quality improvement opportunities as well as bring the perspective of the PCN physicians within their respective clinics.	
Physician quality improvement	• Support physicians in completing practice audits when requested. • Engage physicians in identifying their informal enrollee lists • Support physicians in accessing the AHS chronic disease management registry • Support leadership conferences for interested physicians	• PHCT
Physician Recruitment & Retention	• Develop and implement a comprehensive recruitment and retention strategy for physicians • Establish locums to improve quality of work life • Enhance medical student training opportunities • *Additional detail listed below*	
Physician services provided based on the point system	• To encourage comprehensive family medicine and the maintenance and continuity of care, a system will be implemented that will allocate a reasonable pool of funds to provide incentives for family physicians to maintain hospital privileges, accept new patients into their practice, and work with a select group of unattached patients that can not access regional services unless they are attached to a family physician. • *Additional detail listed below*	

Unattached home care patients	• The PCN physicians will work in collaboration with Home Care and the respective Regional Program and be supported by the Primary Health Care team established to support physicians providing comprehensive patient care. • Unattached patients are defined as patients who do not have a family physician or those patients with a PCN physician that does not provide services such as home visits and is not comfortable or confident in the management of palliative cases. • *Additional detail listed below*	
Evaluation	• Enhance the capacity and ability to measure impact and patient care outcomes with all priority programs • Explore collaborative funding approach • Establish a process to provide physicians with feedback on practice audits and continuous quality improvement initiatives • Explore PCN evaluation or quality improvement with regional and provincial linkages e.g. Towards Optimized Practice (TOP) program	

Physician Remuneration

In the original business plan, physicians were remunerated in accordance to the values that the "quality of work life is financially and professionally rewarding" and "all colleagues are important and all work is valued". The budgeted dollars in this business plan renewal has not changed from the original plan but the allocation and distribution have been re-evaluated.

Physicians who provide the appropriate level of care in the appropriate setting and who maintain an appropriate scope of practice shall qualify to receive additional compensation for managing the most ill or complex patients and for increasing access by accepting "unattached" patients. This strategy or model of remuneration encourages physicians to manage discrete groups of patients. When time and resources are limited and physicians are faced with multiple priorities, the goal of this program is to promote and enhance coverage and care that St. Albert family physicians provide to the residents of St. Albert and Sturgeon County. Increasing the opportunities for more comprehensive patient care and encouraging the equitable distribution of workload to a broader base of physicians, should enhance physician work life. In order to do so, physicians will receive remuneration based on a point system that is unbiased and commensurate to the contribution to comprehensive care, and acceptance of new patients and selected unattached patients into their practice.

The Master Agreement states services to be provided to "an equitable and agreed-upon allocation of unattached patients". Alberta Health Service has requested that the PCN identify 2-3 patient types, agreed upon by CH and PCN that are considered high priority to be attached and to develop strategies with the PCN that would assist physicians in both managing and taking their equitable share of these discrete patient groups.

Physicians are encouraged to manage the individual care of unattached patients with multiple and complex health needs, including the coordination of referrals, results and follow up and will be compensated for the case management of these patients. The unattached

patients are the following - unattached mothers and babies, unattached palliative care and complex/chronic disease patients and unattached mental health care patients.

Point System

To encourage comprehensive family medicine and the maintenance and continuity of care, a system will be implemented that will allocate a reasonable pool of funds to provide incentives for family physicians to maintain hospital privileges, accept new patients into their practice, and work with a select group of unattached patients that can not access regional services unless they are attached to a family physician. In addition, physicians are awarded points for managing a discrete group of patients. Physicians that provide comprehensive patient care and support increased access will be compensated accordingly.

A bi-annual system of remuneration will encourage physicians to continue to maintain both hospital and long-term care privileges thereby sustaining the viability of the facilities to provide comprehensive patient care. If value is placed on the services delivered within facilities settings, perhaps it will attract new physicians to work in these settings.

Diabetes is used as a proxy measure to determine point distribution for chronic disease. All physicians have provided consent for the PCN to work in collaboration with Alberta Health Services to establish a Diabetes Registry. Chronic disease is a burden and the World Health Organization declared chronic disease an epidemic with large economic impact of health expenditures.

With the current remuneration in place, 3 new physicians have accepted hospital and long term care privileges, 9 physicians accept unattached palliative care patients and 18 physicians accept unattached mothers and babies. The PCN would like to continue to build on this success.

A breakdown of services provided and associated points are below.

Services Provided	Patient Volume	# of Points
Admitting Privileges including community on call		40
Long Term Care Privileges	Up to 9	10
Long Term Care Privileges	10+	20
Doing both inpatient and long-term care		5
Accept unattached mothers and babies		5
Registry Proxy for CDM (Diabetes Registry)	Up to 49	10
	50 to 99	20
	100+ per year	30

In the development of the criteria for the points, long term patient care was examined. There is an average of 284 long term care patients at any given point in time and approximately 24 PCN physicians who accept long term care patients. The average number of patients per physician is variable with extreme ranges that could significantly impact the allocation of points. To encourage physicians to take on "their share" of long term care patients, to optimize workload distribution, and to maintain sustainability, a higher index value is incorporated within the points system.

Point allocations will be assessed every six months and physician remuneration will be allocated accordingly. In addition, the following program elements will be in place:

- Physicians' status will be reassessed every 6 months based on a maximum number of long-term care patients carried at any time in the 6 months.
- Diabetes is used as a proxy measure for chronic disease. The St. Albert and Sturgeon PCN is part of the CH Diabetes Registry and it is updated on a regular basis.
- Admitting privileges is a proxy measure for physicians providing comprehensive patient care.
- A process has been established to accept unattached mothers and babies.
- There is not an appropriate informal enrollee size that can be applied across all physicians. Physicians are all unique in their choices, practice styles, and behaviors, some work more/fewer days, some like to see more or few patients per day, and some bring back more/less frequently. To fairly remunerate physicians the following assumption has been factored into the remuneration principles. It is assumed that a full time physician will work 200 days/year X30 visits per day with an average revisit rate of 4 visits/per year. The assumption is that an average informal enrollee size is 1500.
- Physicians will be given points based on community services, and then points are multiplied by .66 (if informal enrollee size is less than 1,050), 1.33 (if informal enrollee size is more than 1,550) or 1 based (if informal enrollee size is between 1,050 and 1,550).

Physician payments will be variable and will be dependent on the workload measurements identified. The maximum amount of resources to be paid to physicians participating within the PCN will not exceed 30% of the PCN per capita funding.

This system will make in-patient care and long-term care sustainable because it will share the responsibility across the physicians in the St. Albert and Sturgeon PCN. The care of medically complex patients often involves the need for inpatient care, either in acute care or in long-term care facilities. This work can be difficult, time consuming and disruptive to office practice. The workload is more manageable and sustainable if shared across the physicians of a community. In addition, the continuity of care for the patient can be of tremendous benefit, with minimization of repetitive testing, and better information flow.

It is important to reiterate, the physician remuneration for the CDM Diabetes Registry is independent from the complex fee code. Registering patients in a central registry, as is contemplated in our point system is not specified as a compensated activity under HSC 03.04J. Patients may be on the CDM Registry and may or may not meet the criteria for a complex care plan. The St. Albert Sturgeon PCN physicians are participating in the ongoing development and maintenance of the Chronic Disease Registry for patients with Diabetes as a management tool. It is anticipated that, by using diabetes as a proxy for other chronic diseases, that this PCN, and its physician membership, will be able to plan programs and allocate resources for chronic disease using a transparent process. This registry allows the PCN membership an opportunity to begin to realize the benefits of a population health data base and opportunities for improvement. Although this is a voluntary activity, 100% of the St. Albert Sturgeon PCN physicians are participating at this time by providing the PCN access to this data. The PCN wishes to continue to support the CDM Diabetes registry as a proxy measure on an ongoing basis to inform decisions related to programs and services for Chronic Disease Management. The remuneration for physicians is to support the time required for physicians to work with the PCN on this administrative data base to gain a better understanding of the value of a registry from a PCN perspective.

Physicians are not compensated or paid any overhead for the PCN multidisciplinary team or for evaluation related to the PCN. It is an expectation that physicians will communicate with the PCN multidisciplinary teams and participate in evaluation as outlined in their service agreement. The following unattached patient honorariums will be paid a maximum hourly rate of $173.44 to a maximum dollar amount of $24,975 per year.

Unattached Home Care Patients

The PCN physicians will work in collaboration with Home Care and the respective Regional Program and be supported by the Primary Health care team established to support physicians providing comprehensive patient care. Unattached is defined as a patient who does not have a family physician or those patients with a PCN physician that does not provide services such as home visits or is comfortable or confident in the management of palliative cases.

Unattached Palliative Care

Currently the PCN has 9 physicians utilizing a formalized triage system as part of a program provided by the Primary Care Network accepting unattached palliative care patients who choose to stay at home with the support of home care. The system involves coordination and integration with regional palliative. To support the physicians in the additional work involved in accepting an unattached complex patient and overseeing the case management and coordination of care for that patient, a stipend will be allocated based on an hourly rate as per PCIC policy. This additional workload has been established at a maximum of 2 hours (time dependent on travel to rural Alberta to complete initial home visit) at a rate of $173.44 per hour. The anticipated volume is 15 patients per year.

Unattached Mental Health Patient

A process will be established with Regional Mental Health to accept unattached Mental Health Patients. The initial process will focus on children under the age of 5 who are unable to access the Regional Neurodevelopment clinic unless they are attached to a family physician. Stipend for accepting unattached mental health patient will be based on an hourly rate as per PCIC policy for a maximum for 2 hours at a rate of pay of $173.44 per hour. The anticipated volume is 10 patients per year.

Unattached Patients with Chronic Conditions

The PCN proposes to support family physicians that are willing to accept unattached patients with chronic conditions. To encourage the additional work involved in accepting an unattached patient with a chronic illness, a stipend will be paid based on an hourly rate as per PCIC policy for a maximum of 2 hours at $173.44 per hour. The anticipated volume is 50 patients per year.

Physician Recruitment & Retention

1. A brief survey was developed and sent to 52 PCN physicians July 2008 to understand the issues of physician recruitment & retention. Results were based on a response rate of 90% (47/52 physicians answered at least one of the survey questions). Of those that answered, 17% indicated that they planned on retiring sometime within the next three years; this does not include those physicians in the community that are not currently part of the PCN, but are planning on retiring in the next three years. From a patient advocate perspective, without a proactive plan to address this situation, the current physicians within the community will feel the impact of those retiring, as patients may potentially fall into the "unattached" patient pool.

Goal

1. To attract two full-time locums per year that will primarily work from the PCN office to maintain and increase access by floating between physician clinics that require a locum.
    - To provide family physicians with the ability to take vacation without increasing backlog and maintaining access for their patients.
    - This strategy should provide the necessary time for both parties, locum and physicians, to assess whether St. Albert and surrounding community is a good professional fit with the hope that the locum would remain in the area after their one-year term.
    - The locums will work on a 70/30 split of their FFS earnings (70% FFS earnings will go directly to the locum with the remaining 30% paid to the clinic for overhead costs), this includes overhead costs to the PCN if locum works from the PCN space.
    - The locums will be required to sign a contract to work full-time for a minimum of one-year that is restricted to this PCN.
    - The locums will provide comprehensive patient care and will have both admitting privileges to hospital and long-term care facilities.

- To attract a full-time physician to join a clinic.
    - A full-time physician that is recruited will sign a contract to work a minimum of one-year restricted to the PCN.
    - This physician will provide comprehensive patient care and will have both admitting privileges to hospital and long-term care facilities.
- To attract the remaining 8 family physicians that do not currently belong to the PCN to provide all St. Albert and Sturgeon Community residents with the same access to support services provided to PCN patients.

Proposal

- Approve funding on a yearly basis over the next three years for the PCN to actively recruit and retain physicians and locums.

Risks & Mitigating Activities Associated with Access to Care Priority Initiative

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Unable to recruit physicians	• Develop and implement recruitment strategy	• PCIC to consider policy changes to articulate rules of engagement for Nurse Practitioner and /or midwifes as CORE provider to maintain or increase access
Infrastructure not in place to evaluate and measure patient outcomes	• Evaluate projects where data base infrastructure is in place such as the Chronic Disease Management Registry • Leverage with other PCN's, AHS other partners to provide evaluation expertise and sound methodologies	• Risk has occurred and provincial strategies are occurring to adopt electronic medical records with capabilities to collect data to measure outcomes
Physicians unwilling to participate in quality improvement projects	• Build required continuing medical education credits into quality improvement projects • Develop trust • Share lessons learned	• Work with early adopters

3.7. Implementation Timeline

Time Period	Key Activities	Deadlines, Goals & Comments
2009	• Complete all service agreements with AHS	• April, 2009
Current-2012	• Continue to build on chronic disease management registry	• 2009-2012- The overall goal is to utilize the registry to proactively manage patients and complete practice audits to support quality improvement
2009	• New PCN space	• move date targeted for March 31st, 2009
	• Recruit full complement of staff	• April, 2009 (carry over funds from 2008/2009 budget year)
2009-2012	• Self help modules	• PIA Part B to be completed for self help modules prior to implementation Fall 2009
2009-2012	• Cyber Therapy	• PIA Part B to be completed for cyber therapy prior to implementation Fall 2009
2009	• Establish service agreement with home care for occupational therapy and pharmacist support	• Fall 2009 most patients that are seen in the Geriatric, Evaluation and management clinic are already under the care of Home care. The goal is to improve the linkage between home care and the GEM clinic
2009	• Provide Cognition and Competency educational sessions for seniors	• Fall 2009 many seniors do not have a living wills and this is a challenge when they can no longer make decisions. The goal is to increase awareness of the importance of a living will.
2010-2011	• Develop new model entitled centering pregnancy for prenatal care	• 2011 Given the shortages of physicians, this model maximizes time by using a group approach to visits.
2009-2012	• Strategy to reduce teen pregnancy in Sturgeon County	• 2012 In collaboration with AHS, develop a strategy to provide education to this targeted group of teenagers.
2009-2012	• Obesity management	• 2012 In collaboration with the AHS Weight Wise Program, the roles and responsibilities will be articulated to integrate and maximize resources avoiding duplication

Time Period	Key Activities	Deadlines, Goals & Comments
2009-2012	• Those At risk for diabetes	• 2012 In collaboration with AHS and the University of Alberta, Health Promotion Department, develop, implement and evaluate a program to target this sub group of patients identified through the AHS Chronic disease management registry.
2009-2012	• Gestational diabetes	• 2012 In collaboration with AHS, determine a process to continue to monitor this select group of women following delivery
2009-2012	• Stop Colorectal cancer through prevention and education	• 2012 In collaboration with AHS provide this screening program within this PCN
2009-2012	• Building capacity of sport coaches	• 2012 The PCN and AHS received a grant last year and a further funding request has gone in for the 2009-2010 fiscal year.
2009-2012	• Access to care	• 2012 The overall goal is to work with physicians to increase their capacity
2009-2012	• Quality improvement working group	• 2012 The overall goal is to develop a culture of continuous quality improvement within the physician community
2009-2012	• Physician recruitment & retention	• 2012 The goal is to actively recruit and retain physicians to meet the needs of the communities we serve
2009-2012	• Evaluation	• 2012 The overall goal is to have information to the Board to enable them to make informed decisions with respect to the programs implemented and the teams that work with physicians

4. Legal Structure

Legal Form of Business

The following documents with respect to the incorporation and organization of a non-for-profit company are on file with the Primary Care Initiative Program Office:

1. Incorporation Certificate showing the incorporation of 1211206 Alberta Ltd. on December 16, 2005 as a not-for-profit company;
2. Memorandum of Association of 1211206 Alberta Ltd;
3. Articles of Association of 1211206 Alberta Ltd;
4. Notice of Address;
5. Notice of Directors;
6. Registration Statement dated December 16, 2005;

The NPC is obligated to fulfill the spirit and objectives of the business plan under the guidance of the Governance Committee (GC). The NPC is responsible for the day-to-day operation of the PCN. The NPC's responsibilities include managing the funds received based on the funding model that has been established and overseeing all financial transactions. Physician services, hiring of personnel required to operate and contracting the appropriate consultants are also the responsibility of the NPC.

Term of Operation

The term of Agreement is April 1st, 2009- March 31, 2012. The provision of continuance is dependant on the negotiations that occur within the Master Agreement regarding the "Trilateral Relationship and Budget Management Process for Strategic Physician Agreements" made among the Alberta Medical Association, Alberta Health and Wellness, and AHS.

Renegotiation Provisions

It is expected that the Governance Committee will continue to oversee the implementation of the business plan. The committee is made up of two representatives of Alberta Health Service and two representatives of the NPC. As the plan is a living document it is anticipated that from time-to-time changes to the business plan and to the agreement may be contemplated.

- Signatories to the business plan acknowledge that all material changes to the business plan require prior written approval of the PCIC, as specified in PCI Policy Manual, and that they agree to abide by PCIC's policies regarding business plan amendments as may be developed and amended by the PCIC from time to time.
- Signatories to the business plan agree not to amend the business plan in any manner that compromises or limits their obligations to fulfill the objectives set out in section 3.1(e) of the PCI Agreement or to deliver all of the service responsibilities set out in section 8.1 of the PCI Agreement or as further defined by the PCIC from time to time.

Program development is in collaboration between representatives of Alberta Health Service and physician members of the NPC. If the program development committees determine that there is a need for change in the business plan then the suggestions will be reviewed by the Governance Committee and denied or forwarded to PCIC for approval depending on their impact on the business plan.

The Governance Committee meets four times per year to review the progress of the PCN and assess the progress against the business plan. The NPC meets 9 times per year and will undertake a similar type of review during its meetings. A general annual membership meeting is held.

Entry/Exit of Physicians

Physicians may enter the NPC by signing the Business Plan, the Letter of Participation in the Joint Venture Agreement, and other documentation related to joining the NPC. The documentation confirms the Physician as a member of the NPC and the commitment to support the objectives of the PCN. Acceptance of the physician into the NPC is conditional on the physician meeting predetermined criteria for membership. A physician may resign from the NPC at any time subject to fulfilling any obligations or responsibilities acquired at the time of membership. The NPC may terminate a member who fails to meet their obligations following a 30-day notice of remedy.

Termination Provisions

Either party to the Joint Venture Agreement may terminate their association with the PCN with not less than 90-days written notice to the other party and the PCIC.

5. PCN Governance and Organization

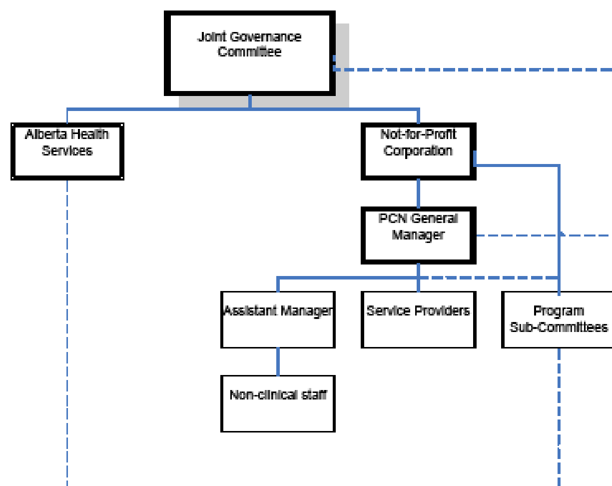
Governance Structure

The PCN is a joint venture between a Not-for-Profit Corporation, representing the physicians, and Alberta Health Service (see Figure 1 below). A Governance Committee of representatives from each party will govern the PCN and decision-making will be by consensus.

The Governance Committee will be comprised of four Members; two from each Party. Allowance will be made for additional Members and/or ex-officio Members, as the Committee deems necessary. Decision-making will remain by consensus even in the scenario where one party has more Committee Members than the other. The Governance Committee will have overall responsibility for the PCN and oversight over the Business Plan and budget. Strategic direction will be guided by the Governance Committee and this Committee will have responsibility for high value transactions such as expenditures over $100,000, the hiring or termination of senior staff, and commitments longer than one year.

The NPC, as a separate corporation, has its own Board of Directors. These Directors are Members of the NPC and have been selected by the Membership. Two members of this Board represent the NPC on the Governance Committee. As like-minded physicians are engaged to join the PCN, provisions will be made to ensure appropriate representation on the NPC Board of Directors. The NPC will have responsibility for day-to-day operations of the PCN and be accountable to its Membership and the Governance Committee for delivering on the goals and objectives of the PCN. Management, staff and contracted physicians will be accountable to the NPC Board. In practical terms, the NPC Board of Directors will act as an 'Executive' for the PCN.

Figure 1: Governance Structure



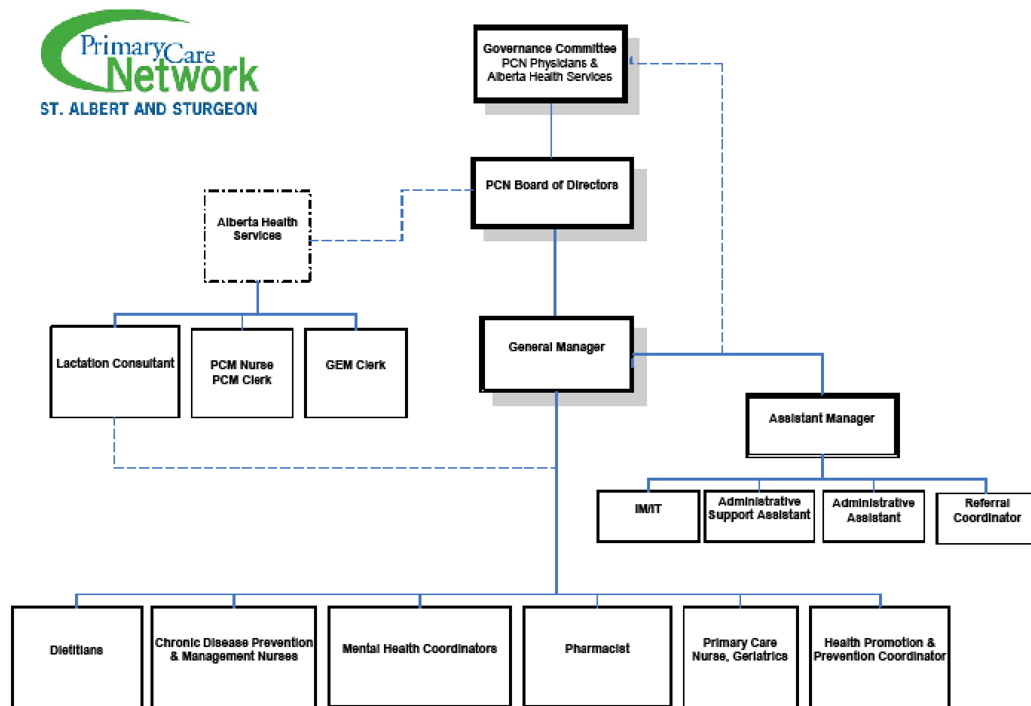
Organizational Structure

The PCN will be directed by the Governance Committee, comprised of representatives of Alberta Health Service and the Not-for-Profit Corporation (NPC). The PCN General Manager reports directly to the NPC and is accountable to the parties to the Joint Venture Agreement (NPC and Alberta Health Service) through the Governance Committee. The General Manager is responsible for implementation of the business plan and management of day-to-day operations, with the assistance of the Assistant Manager.

Organizational Chart

Below is the current PCN organizational chart (Figure 2).

Figure 2: Organizational Chart



Roles and Responsibilities

Governance Committee

The Governance Committee is comprised of members of Alberta Health Service and NPC and be responsible for ensuring the business plan is implemented and for the approval of detailed service delivery plans. The committee is scheduled to meet on a quarterly basis; NPC representatives will be compensated on the agreed upon rate for hourly honorariums by PCIC. Strategic direction will be guided by the Governance Committee and this Committee will have responsibility for high value transactions such as expenditures over $100,000, the hiring or termination of senior staff, and commitments longer than one year.

Alberta Health Service

The AHS will work in co-operation with the NPC and ensure that regional health objectives are addressed.

Non-Profit Corporation Board of Directors

The NPC Board, is comprised of five physician members and a Chair, and is responsible for ensuring that the objectives of the physicians are addressed in the PCN. The NPC will also be the source for members participating on the program sub-committees. The NPC Board is responsible for the operations of the PCN through the General Manager. Board Meetings will be held no less than eight times per year. Board quorum will be attendance of 50% + one. The Board shall keep minutes of its proceedings and the Chair shall report all material matters at the Annual Meeting. Physicians members will be compensated on the agreed upon rate for hourly honorariums by PCIC. The Chair will be provided with a yearly stipend.

PCN General Manager

The PCN General Manager reports directly to the NPC and is accountable to the parties of the Joint Venture Agreement (NPC and Alberta Health Service) through the Governance Committee. The General Manager is responsible for implementing the business plan, managing the day-to-day operations of the PCN (including all PCN related agreements), and providing data and reports as needed to the Governance Committee. The General Manager also supervises and oversees the clinical team by providing guidance and clinical leadership. The General Manager will be contracted on a yearly basis and will be on a salary.

PCN Assistant Manager

Under the supervision of the General Manager, the PCN Assistant Manager works as part of the management team to supervise delegated PCN staff and administrative support on an executive level. Functions of responsibility include – HR, Payroll, Financial, Facilities and Office management, as well as IM/IT. The Assistant Manager will be contracted on a yearly basis and will be on a salary.

Program Chairs

The Program Chairs are comprised of 5 PCN Program Lead Physicians who will oversee the key elements for priority service areas identified in the business plan. Time commitments for Program Lead Physician participation has been estimated at 2 hours per week for 48 weeks.

Dispute Resolution

Dispute resolutions begin with good faith negotiation by both parties. If the matter cannot be resolved in this manner then a dispute resolution committee is to be formed comprised of senior officers of the NPC and Alberta Health Service. At anytime after 15 days, if this committee is unable to resolve the dispute, either party may request an independent knowledgeable mediator to be retained to assist the Parties. Should mediation not resolve the dispute, either party may request arbitration. The Joint Venture Agreement contains details on how the arbitration process will work and which party will bear the cost of arbitration. At all times the Parties must continue the performance of their respective obligations within the PCN.

Consequences for Failure to Meet Obligations

Physician members of the PCN will be accountable to each other under the terms and conditions of a Not-for-Profit Corporation (NPC) and in a manner consistent with codes of conduct, ethical standards and professional practices prescribed by the College of Physicians and Surgeons of Alberta. Failure to comply with the terms and conditions of the NPC by any member physician could result in the termination of the membership and loss of all privileges in the PCN.

The Joint Venture Agreement articulates the roles, responsibilities and accountability of the PCN and AHS. Both parties will be jointly accountable to the Primary Care Initiative Committee, and have a responsibility for the success of the PCN, on a reasonable basis, as described in the joint venture agreement and the business plan.

Within the PCN, the General Manager and staff will be accountable to the NPC in an employer-employee relationship through the NPC. These positions will be measured against specific job descriptions and duties. Health professionals employed by the PCN must perform their duties in keeping with their professional designations and accreditation and are accountable to their professional bodies. In addition, the General Manager will be accountable to the parties of the Joint Venture Agreement (physicians and Alberta Health Services) through the Governance Committee.

6. Information Management

Current Status

Almost all physicians are using electronic charting, although to varying degrees. There appears to be little consistency between the use of some terminology and functionality (i.e. problem lists, template use, history, encounter notes, etc). 83% of clinics (10 out of 12 clinics) used the electronic scheduling and billing capabilities.

Most clinics (91% of those interviewed) are using the internet to access online medical knowledge tools, the most common being Up-To-Date. Almost exclusively the clinics that are using EMRs for their day-to-day activities expressed great frustration with the lack of vendor support, lack of communication about future upgrades or system enhancements and expensive post-upgrade/implementation training.

The majority of physicians are comfortable sharing a patient record, as long as the patient consents. Generally it is the medical summary which includes the history, medications, allergies, and results that has been shared. Of concern amongst some physicians is the protection of the physician-patient relationship.

Primary Care Maternity created a challenge for information management as encounter notes are considered necessary for the continuity of care. There is a high demand to chart the encounters at the Sturgeon and Castledowns Maternity Clinics. There is also a need to have the prenatal form available electronically. Due to the business model, a patient may see multiple physicians regarding their prenatal care, and ultimately a different physician could deliver the baby. As a result there is a need to document and share prenatal visits once the patient is further along in their pregnancy. This was indicated as a high priority clinical requirement for this subset of physicians. Some resistance to the sharing of encounter notes occurred but with appropriate communication and clarification access was granted.

Another issue that was expressed by the physicians was data migration to a new EMR. While many questions were raised, at this point in time, it is unclear how this will be resolved.

PCN Awareness

In general the physicians are highly supportive of the role the PCN plays and has found great value in the associated care the allied health professionals provide. Physicians believe their patients are receiving better care and follow up through the efforts of the PCN staff although they have identified there is still some room for improvement. If the PCN selects one EMR system, the clinics have expressed interest in the referral forms to the PCN becoming available online to streamline the work flow.

Major Themes

Several major themes became apparent during the interviews. These were:

- Confidence surrounding the completeness and accuracy of the electronic results received
- Desirability for interoperability
- Moving more and more to a paperless environment
- Concern over data migration when transitioning

Recommendations

The major recommendations include:

- PCN should move to one EMR to achieve the level of interoperability desired
- Maternity clinics should be integrated into the EMR for charting and continuity of care purposes
- The chosen solution should be capable to integrate with the Netcare Portal
- The PCN referral form should be available electronically in the EMR
- Diagnostic imaging duplicate issue should be resolved or reduced
- The creation and maintenance of a specialist database and what the specialists require prior to accepting patients (a provincial solution has been proposed with timelines for implementation in 2010)
    - This would be a project the referral coordinator would help to maintain for the PCN
- Remote access at home, the hospital, patient homes, and anywhere there is an internet connection

The service gaps and objectives this specific initiative intends to address in order to assist all the priority initiatives and the physicians are:

Element	Description	Resource Requirements
Collaboration with POSP, clinic managers, regional and provincial Information Management programs to support efficient and timely exchange of information	• A comprehensive information technology plan does not exist provincially, regionally or within the PCN. As such, current Electronic Medical Records (EMRs) in family physician offices are limited their capability to integrate with regional and provincial databases or to identify specific patient groups to develop registries. • Collaboration & utilization of reliable, current and accessible information management systems and tools available to assist in the enhancement of patients primary care and health outcomes.	
System Analysts	**Key roles and responsibilities include:** • Supports users technical information requests and resolves application, operating system and hardware problems in a proactive manner. • Assists with and performs hardware and software installation and upgrades as required on network computer infrastructures. • Provides recommendations and assistance to ensure the integrity and security of applications and data stored with each clinic, follows industry, legislative & POSP standards.	

	• Provides Business Continuity Planning for the clinics so that plans are in place in the event that system failures occur. • Supports and advises on strategies to enhance communication between the Primary care Physicians and the Primary Health Care Team • Records and maintains hardware and software inventories, site and/or server licensing, and user access and security. • Responsible for all aspects of clinical/administrative systems applications support, while anticipating future requirements, trends, and changes to the current and future needs of the PCN.	

Risks & Mitigating Activities Associated with IM/IT

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
No clear direction to date on the POSP support that will be provided to family physicians with respect to their current EMR	• Collaboration with POSP to develop and implement transitional planning for EMR change over and be kept in the "loop" of what is happening and how it will impact the PCN	• Appropriate communication, as required, with current PCN physicians to ensure they are aware of benefits and disadvantages of changing their current EMR system to enable them to make informed business choices regarding the impact of the new EMR
EMR vendor interference with patient files, such as: • Modifying the program to make it more difficult to extract information from it • Adding features to prevent the application from being used at a future date • Corruption of existing data • Discontinuation of support for existing clients during the change over process	• Keeping on top of the various changes and stages of the EMR change over to ensure things go as smoothly as possible	• POSP is doing a risk assessment of issues • PCN IM/IT team will review risks and bring forward recommendations to protect the PCN physicians

Privacy Impact Assessment Status

The PCN recognizes and respects the importance of maintaining the privacy of patient information. It is critical that the PCN balance the need for professionals providing health services to access information required to treat patients and the rights of the patient when dealing with their health record. The multidisciplinary model encouraged by the Primary Care Initiative requires that patient information be shared among many health professionals to ensure that the needs and concerns of a patient are addressed, thus increasing the probability of a good health outcome for the patient.

The PIA for the PCN will be sensitive to the privacy needs of both parties and will strive to ensure that issues of patient confidentiality will be reviewed from the perspective of AHS, the participating physicians, the allied health providers and the patient.

# of Physicians Covered	Clinic/Physician Office	File Number for Accepted PIA
12	Grandin Medical Clinic	H0442
6	Associate Medical Clinic	H0558
4	Dr. Lidkea and Associates	H0367
5	Salvus Medical Clinic	H0680
5	Summit Clinic	H0274
4	Solace Clinic	H0816
4	Dr. John Clarke, Dr. Deidre Clark and Dr. Kuc	H1136
3	Liberton Medical Clinic	H0152
3	Mission Hill Medical Clinic	H1272
1	Dr. Wayne Daviduck	Moved to solo practice from Salvus clinic. PIA submitted.
1	Dr. Meghna P. Juta	PIA submitted.
1	Dr. Harvey E. Albrecht	H0647
2	Tudor Glen Medical Clinic	H1382
1	Dr. Dennis Glubish	H1137
1	PIA for Pharmafile	H1976
52	PIA for the PCN	H1137, an amendment in progress due to new location

Risk Assessment

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Financial Risks		
Physician hourly rates and staff increases continue to rise yearly with no corresponding increase of the $50 per capita payment	• Factor a 4.5% increase yearly in the budget process as per PCIC policy and/or direction • Write a letter to PCIC to articulating implications of human resource costs to the PCN	• Downsize staffing complement to match resources
Decrease in enrollees due to inability to recruit physicians	• Recruitment and retention strategy developed and to be implemented	• Downsize staffing complement to match resources • Request PCIC approval to approve nurse practitioners and/or midwives as core providers to maintain and improve access to care
Uncertain funding amounts as enrollee numbers change	• Monitor policy development regarding funding • Integrate and collaborate with regional programs to ensure duplication is not occurring • Determine physician's informal enrollee list and continue to support AIM to look at efficiencies within the office setting and continuity of care	• Miscellaneous expenses and plans for its use if not required.
Lease costs increase substantially	• Establish longer lease terms with owners	• Close Morinville site
Patient Safety, Legal, and Liability Risks		
Liability associated with sharing of care among multidisciplinary team members	• Ensure all healthcare professionals, including physicians, are appropriately credentialed and insured	• Address matters of concern promptly.

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Adverse patient outcomes resulting from presence at or treatment through PCN programming	• Quality Improvement Working Committee established • Ensure clinical practice guidelines, care maps and protocols are in place • Carry proper insurance.	• Engage legal counsel
Human Resource Risks		
Inability to recruit and retain qualified staff	• Develop appropriate recruitment strategies, including identification of suitable candidates from within existing staff. • A staff manual has been implemented and is reviewed and updated as required based on market analysis	• Develop alternate service delivery methodology.
Health Information and Privacy Risks		
Poor decision making due to lack of experience in making collective decisions	• Establish appropriate physician governance structure.	• Address matters of concern promptly through communication mechanisms and governance structure.
Breach of privacy	The PCN currently has the following in place: • User access to data is secured with multiple levels of password and/or RSA SecureID fobs. • Communication and data stored on the server is encrypted and encryption using SSL is in place for all web and e-mail access. • Policies are in place regarding removable storage (e.g. CD's, memory sticks, etc.) that contain confidential information. • Ensure physician clinic PIAs are complete before adding new physicians	• Ensure all scenarios are considered and policies are put in place and all stakeholders are aware of the steps that need to be taken should a breach occur. • Ensure IT professionals are kept up to date with the latest technologies and threats that may attack the IT infrastructure.

Description of Risk	Activities to Mitigate/Prevent the Risk from Occurring	Strategies to Address the Risk Should it Occur
Limited interconnectivity	• Continue to work with and through the various PCN physician clinics to ensure access to the necessary systems (e.g. Netcare) are available and remain secure • Continue to engage POSP	• Encourage physicians to select one vendor when provincial decisions are made
Breach of patient confidentiality	• All clinical PCN staff has EMR access with their own access code and RSA SecurID fobs so physicians are aware of who is accessing their system and why.	• Consider termination as per PCN policy
Insurance Coverage and Risk Management		
Liability Issues related to legal risks associated with professional liability, financial, taxation and labor relations.	• A joint venture agreement has been executed and a governance model is in place • Insurance to protect the PCN, PCN staff, physicians, committee and Board members and executive staff with regards to bodily injury (including medical malpractice), property damage and error & omissions (all inclusive of Directors & Officers and Employee Benefits) • Insurance policy is updated and validated yearly	• Legal counsel has been retained
Physicians do not want to incur additional liability risk due to the actions of a different provider within the PCN	• A process has been established to ensure all health care professionals, including physicians, are appropriately credentialed and insured • Roles and responsibilities have been clearly articulated according to approved scope of practice and documented in the provider's job description	• Insurance policy is updated and validated yearly
Volunteer relations not clearly articulated	• Policies should include screening of the volunteer, clear role description and appropriate orientation	• Insurance policy is updated and validated yearly
Contractors not completing agreed upon services	• All contractors sign a return service agreement which includes a confidentiality clause • All contractors need to provide a proof of insurance for their company	• Insurance policy is updated and validated yearly • Legal counsel has been retained

7. Communications

The overarching goal is to develop a high level of awareness of and support for the PCN by all audiences. The General Manager in collaboration with Alberta Health Services Public Affairs will continue to build on the work completed on communications that supports PCN activity with stakeholders.

All physicians, PCN office and clinical staff have been provided with standardized patient information brochures to support consistent messages to patients. The PCN has adopted/ adapted tools developed by the PCI Program to support the PCN communications.

In addition to the provincial measurement strategies such as the AMA tracking surveys, and a benchmark public survey, the PCN has complemented the communication evaluation strategies completed provincially by collecting baseline information on physician and PCN provider satisfaction within the selected priority service responsibilities which has facilitated the development of this Business Plan.
The General Manager will continue to have ongoing responsibility to build productive relationships with the membership and key stakeholders to raise the PCN's profile in the community.

A major undertaking has been the development of the St. Albert and Sturgeon PCN website at http://www.stalbertsturgeonpcn.com. The website includes the following:

- Contact details for the PCN and member clinics, and answers to frequently asked questions about the PCN
- Information about educational sessions
- Resources in areas like maternity care, mental health and nutrition, and links to other health related sites

The website has achieved good visibility and is the first search result obtained for 'St. Albert PCN' and 'Sturgeon PCN', and is the number one result for general terms such as 'St. Albert maternity'.

In addition to the website, various communication vehicles have been used to provide consistent messages to health care professionals, patients and public.

Audience	What will be communicated
Physicians connected to the PCN	• Key messages with respect to the PCN goals, objectives and public/patient message • Update on implementation of key service responsibilities • Minutes from all committee structure available for review
PCN staff and physician office managers	• Key messages with respect to the PCN goals, objectives and public/patient message • Update on implementation of key service responsibilities • Minutes from all committees available for review, including CH relevant committees

Audience	What will be communicated
Patients in the PCN and Public	• Key messages with respect to the PCN goals and objectives • Information developed with respect to primary care from a provincial level, information from a regional level and specific information on the local PCN • Capital Health Link
Alberta Health Service staff providing direct services to PCN patients (i.e. Home Care case managers)	• Key messages with respect to the PCN goals and objectives • Patient progress and summary reports

8. Evaluation of the PCN

Success for the St. Albert and Sturgeon PCN includes improvements to patient care, support for family physicians providing comprehensive care and positive interactions with Alberta Health Services, community organizations and other PCN's. Individuals and their families are the clients, patients and consumers of primary health care. Patient/client engagement in their own health issues and health related decisions, together with corresponding client-centered approach by health professionals, is a fundamental operating principle for the St. Albert and Sturgeon PCN. Patients are actively engaged in decisions and management of their health status. Patient/client privacy and confidentiality are always paramount. Specifically, success would be demonstrated by:

- Enhanced linkages between acute care, community services and family physicians leading to increased continuity of care
- Successful integration of multidisciplinary teams into physicians' practices
- Enhanced quality of work life for PCN physicians and other health care professionals
- Long-term sustainability of the family physician workforce and sufficient resources for other health care professionals to support coordinated and integrated access to primary care
- Enhanced ability to care for patients with chronic diseases
- Multidisciplinary collaboration with patients having access to the "right service, provided at the right time, in the right place and by the right professional"
- Geographical barriers minimized and services available close to where people live, work and learn
- Enhanced electronic information infrastructure to support communication with all members of the health care team.

Infrastructure and information required to address the Provincial Objectives

Objective 1: To increase the proportion of residents with ready access to primary care

Examples of some indicators to monitor for increased access:

- The number of mothers and babies attached who have reported no family physician
- The number of unattached palliative, complex and or Chronic Disease management patients attached
- The number of Other Health Care Provider encounters

- The number of new physicians joining the PCN as part of the recruitment and retention strategy
- Measure Access Improvement through AIM with the time to 3rd next available appointment

Sources of information include operational and planning reports from AHW and monitoring of data by the PCN

Objective 2: To provide coordinated 24 hour, 7-day-per-week management of access to appropriate primary care services

- The linkage to Primary Care Maternity
- Number of physicians practicing palliative care

Objective 3: To increase the emphasis on health promotion, disease and injury prevention, care of the medically complex patient, and care of patients with chronic disease

- The number of ALPHA tools completed in the Primary Care Maternity Clinics
- The number of physicians engaged in the Health Outcomes Initiative
- The number of coaches engaged with the PCN in providing education for smokeless tobacco with youths
- Patient satisfaction scores related to educational sessions being provided

Strategies include baseline measures and subsequent measures obtained from the Chronic Disease Management Registry

- Establish a data base for the collection of baseline measures for SCOPE
- Establish a data base for the collection of baseline measures for the obesity program and the At Risk Group and a process for follow up

Objective 4: To improve coordination and integration with other health care services, including secondary, tertiary, and long-term care through specialty care linkages to primary care

- The number of Service Agreements between the Primary Care Network and Alberta Health Services
- The number of formal specialty linkages established

Objective 5: To facilitate the greater use of multidisciplinary teams to provide comprehensive primary care

- The number of discrete patients seen by other health care providers. This information includes the number of patients accessing multidisciplinary care teams by type and service provider.
- The number of patients directly accessing the Primary Health Care Team without a physician referral
- The number of physicians' utilizing the multidisciplinary care teams
- Physician satisfaction with programs established

Currently the PCN has allocated a 0.2 FTE Service Agreement with Alberta Health Services for evaluation support. In addition, a 0.2 FTE has been allocated for data entry for OHCPs.

Appendix A: Service Delivery Plan

Service Responsibility	Description of the programming and resources currently available to address the service responsibility	Direct ways in which the PCN intends to enhance delivery of care during the term of this business plan
1. Basic ambulatory care and follow-up	Basic ambulatory care and follow-up are currently provided by: • Thirteen clinics with 50 physicians, 2 satellite clinic in Morinville • Physicians also work in various outpatient/ambulatory clinics (e.g. I.V. & Asthma) at the Sturgeon Community Hospital • Community Health, Mental Health and Home Care Staff provide home and clinic-based care • Wound clinic available through home care 7 days a week	Service responsibility is well covered by the PCN physician, other non-affiliated physicians and AHS. No significant gaps identified to date and this will be monitored as part of the PCN operations.
2. Care of complex problems and follow-up *The St Albert and Sturgeon PCN does not differentiate the "care of complex problems and follow up" as a distinct service responsibility from chronic, mental health or geriatric patients*	The PCN will: • Continue to engage the Primary Health Care Team to manage patients with chronic diseases • Continue to utilize the AHS Chronic Disease Management Registry to manage patients • Collaborate and integrate with Alexander Reserve • Alignment with Home Care to receive unattached palliative care patients and patients with complex/and or chronic disease • Alignment with the AHS chronic disease programs • Educational sessions for patients to better self manage	• Continue to work with family physicians to have PHCT work to their full scope of practice. For example, have the pharmacist prescribe when appropriate • When information from Alberta Health and Wellness becomes available, identify physicians' informal enrollees • Implement a process to better communicate with Alexander Reserve on patients seen by PCN family physicians • Continue to add patients to the AHS chronic disease management registry and develop processes to recall select groups of patients • Attach unattached palliative, and complex/chronic patients through the PCN • Recruitment of a referral coordinator to support family physicians with referrals to specialists • Explore self help learning modules for patients with chronic disease such as diabetes.
3. Psychological counseling	The PCN will:	Access to mental health therapy

	• Continue to engage the mental health coordinators to facilitate the care of adult and pediatric patients • Alignment with St. Albert Family Resource Centre • Alignment and integration with AHS mental health services and Sturgeon Community Hospital • Continue to engage a psychiatrist availability through specialist linkages • Provide educational sessions for patients to better self manage	• Recruit a mental health coordinator trained in Cognitive Behavior Therapy and providing therapy for patients with chronic disease • Implement and evaluate self-help learning modules on line for patients with depression and anxiety • Implement and evaluate Cyber Therapy Recruit family physicians to support the AHS Pediatric Development and Mental Health Program
4. Screening/chronic disease prevention	Previous Business Plan was limited in its focus on health promotion and prevention. Several key initiatives have been articulated.	• Integrate with AHS and implement the Weight Wise Program within St. Albert and Sturgeon community • In collaboration with AHS Food and Nutrition, develop and implement a program for at risk for diabetes patients • Develop a process to include women who have been diagnosed with gestational diabetes and add them to the AHS chronic disease registry • In collaboration with AHS implementation of "Stop Colorectal Cancer through Prevention and Education" screening program (SCOPE) • In collaboration with AHS , continue to work with coaches to build their capacity to deliver tobacco reduction strategies
5. Family planning and pregnancy counseling	A wide range of family planning and pregnancy counseling service care currently provided by PCN family physicians and AHS including: • Counseling by all physicians • Pregnancy counseling by physicians providing primary maternity care • Informal patient referrals among the physicians contingent on patient preference	There is a high teen pregnancy rate in the Sturgeon County in comparison to Edmonton and surrounding area. This has been identified in 3.5 Primary Care Maternity Priority Initiative. It is anticipated to work with the Physician Lead – Primary Care Maternity to provide increased awareness to teens within this geographic area

	• The Birth Control and STD clinic in Edmonton • Health for 2 Program; and • Prenatal classes offered at the Sturgeon Hospital and in community settings	
6. Well-child care	Well-child care services currently offered by physicians and AHS include: • In-office care by all physicians • Eleven physicians provide in hospital newborn care • Participation in pediatric call and care for unattached neonates by five physicians • Ongoing liaison with tertiary care services located in Edmonton • Regional lactation support with two local physicians with lactation expertise • AHS offers o Child Health Clinics- normal growth and development and immunization o Neurodevelopment clinics o Tobacco Reduction Smoking Cessation Support o - Healthy Beginnings	Service responsibility is well covered by the PCN physicians, other non-affiliated physicians and AHS. No significant gaps identified to date and this will be monitored as part of the PCN operations
7. Obstetrical care	• Two primary care maternity clinics that offer obstetrical patient care • Eighteen family physicians accept unattached mother and babies • A lactation consultant provides breastfeeding support	A new model entitled "centering pregnancy" will be implemented for prenatal care
8. Palliative care	Current palliative care service provided include: • Continuous and comprehensive management of care by physicians with 9 physicians accepting unattached palliative care patients • Extended home care for terminal patients, which is made possible by the strong hospital affiliations of the physicians • Strong consultant relationship with the Regional Palliative and home care team • One bed in Youville Home	A process has been established to attach unattached palliative care patients with family physicians
9. Geriatric care	• Centralized booking system through Health Link for referrals to see a geriatrician • A nurse that completes comprehensive geriatric assessments • Liaison with St. Albert Mobilization Committee	This gap previously identified in the first Business Plan is now covered by the PCN, AHS geriatric program and the Sturgeon Community Hospital and will continue to be a

	• Educational sessions for patients to better self manage	priority initiative
10. Care of chronically ill patients	• Refer to service responsibility #2 Care of complex problems and follow-up	
11. Minor surgery	Current minor surgical services include: • Various procedures provided in-office e.g. suturing • Further services provided by physicians in the outpatient clinic (e.g. cast changes)	Service responsibility is well covered by the PCN physicians, other non-affiliated physicians, and AHS. No significant gaps identified at this time but will continue to be monitored as part of the PCN operations
12. Minor emergency care	Minor emergency care service currently provided include: • Reserving emergency slots in clinic schedules • Walk in services for patients requiring minor emergency care • Regional Mental Health Crisis Response Team provides mobile crisis response services to the St. Albert community 24/7 • Hospital based Mental Health Crisis Team supports hospital crisis care for emergency and inpatient units • Accessing x-rays via established relationships with hospital and private DI • 24 hour telephone advice and information through AHS Health Link	Service responsibility is well covered by the PCN physicians, other non-affiliated physicians, and AHS. No significant gaps identified at this time but will be monitored as part of the PCN operations
13. Primary in-patient care including hospitals and long-term care institutions	Currently primary inpatient care services including hospital and long-term care include the following: • A hospital care team unit which takes on unattached in-patient care • 24 out of 50 physicians have hospital privileges • 24 out of 50 physicians have privileges at long-term care institutions	To provide comprehensive and coordinated patient care, family physicians continue to be encouraged to maintain primary in-patient care including hospital and long-term-care. As new physicians enter the PCN, they are encouraged to provide comprehensive and coordinated care.
14. Rehabilitative care	Current rehabilitative care services provided include: • Private services from a variety of physio and occupational therapists in the area • Neighborhood Chat- for stroke survivors with aphasia • Community, psychiatric, Home Care, vocational rehabilitation services • Adult day program at the Sturgeon Community Hospital • Audiology and speech-language programs for children • Home Care post hospital discharge protocols for post cardiac, TURPS, orthopedic hip, and orthopedic knee surgeries, HPT	Through a service agreement with AHS Home Care, an occupational therapist will support the Geriatric clinic 1 day a week.

15. Information Management	• Two full time PCN staff support family physicians and the PCN in information technology needs • All clinical PCN staff have remote access to the physicians EMR • A website has been developed for the PCN	Continue to enhance the information on the website available to the public
16. Population health	Currently population health services provided by AHS and physicians include: • School Health Nursing- tobacco reduction, injury prevention and health sexuality • Environmental Health Services • Anger and stress management • Pre-term birth prevention • Flu clinics/pneumo vaccine • Immunization services	In collaboration with AHS, continue to provide data for the AHS chronic disease management registry
17. 24-hour, 7-day per-week management of access to appropriate primary care services	Currently 24/7 day per week management of access to appropriate services include: • Nine family physicians accept unattached palliative care patients 24/7 • 24/50 physicians have hospital privileges and provide care to their patients in the Emergency Room 24/7. • 24/50 physicians have long-term care privileges and provide care 24/7. • Eleven Primary care physicians do Obstetrics and provide call 24/7 • The Grandin clinic has extended hours Monday to Thursday up to 2000 hours and are open on Saturday from 0900-1200. Each day there is a physician on call during office hours who is not booked and accepts same day appointments. In addition, a physician is on call 24/7. • One clinic takes no booked appointments in the afternoons and has same day access for .5 of the day, 5 days a week. • 24 hour telephone advice and information through AHS Health Link • Two clinics are improving access through participation and implementation of AIM principles	Increase physician capacity by engaging the PHCT to their full scope of practice. Increase physician capacity by engaging physicians in the Alberta AIM (Access Improvement Measures) to decrease waits for patients and redesign clinical care delivery systems
18. Access to laboratory and diagnostic imaging	47 out of 50 physicians have an EMR. All are receiving laboratory results electronically.	All clinical PCN staff have remote access to the physicians EMR and to Net Care

19. Coordination of: home care, emergency room service, long-term care, secondary care, and public health	Currently Home Care services provided include: • Home Care case management of patients with chronic illness and community support • Short term professional services • Long-term professional and personal care • 24/7 access to an on call nurse Currently Emergency room services include: • Full-time casualty officers providing comprehensive emergency care • Mental Health Crisis Team; and • Sexual Assault Response Team Long Term Services provided include: • Beds at Aspen, Heritage, Youville institutions • Access to continuing care facilities including respite services and special program such as dialysis • Supportive living-block funded Home Care, Personal Care Homes, Special Care Homes, Mental Health Approved Homes, Family Care Homes • Designated Assisted Living • Psychiatric nursing/psychiatric consulting services available in Continuing care Centers upon physician request Secondary Care currently provided includes: • 60 in-patient medical beds; 44 surgical beds with 5 operating room theatres; 10 coronary care beds; 5 intensive care beds; 2 child health beds; 23 beds for labor and delivery; and 15 stretchers designated for day surgery. • Neuro-development clinic • Early Intervention Program for developmentally delayed and disabled children and their families • Psychiatric Liaison Service to inpatient units provided by in-house psychiatrists • Geri-Psychiatrist through out patient services	Service agreements with AHS Healthy Beginnings and AHS home care are part of the Business Plan to enhance continuity of care

20. Acceptance into the PCN patient population and provision of the service responsibilities to an equitable and agreed upon allocation of unattached patients.	• Nine physician accept unattached palliative care patients • Eighteen family physicians accept unattached mothers and babies following delivery	A process is being planned to attach mental health patients and complex patients under the care of home care to a family physician