## Calgary West Central Primary Care Network

# BUSINESS PLAN Renewal (BPR)

**Version 2.0**

**CONFIDENTIAL**

**April 1, 2022, to March 31, 2025**

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# Alberta Health 2022-2025 BPR Messaging

**Alignment of PCN Business Plans with Zone Service Plan**

PCN Business Plans must demonstrate how the PCN will work toward achieving the outcomes of the PCN Governance Framework and the Zone Service Plan, which are:

- **Improved integration** between PCN services, AHS programs, and services provided by community-based organizations.
- **Increased alignment** of services across communities within a zone to prevent duplication and to ensure there are no gaps.
- **Shared administrative services** across the zone, where deemed appropriate by mutual agreement between joint partners.

PCNs are also expected to show how they are committed and contributing to the development and implementation of the Zone Service Plan.

To achieve the outcomes of the PCN Governance Framework, individual PCNs must contribute to and support their Zone PCN Committee and the Provincial PCN Committee as set out in **Section 14.7 *Zone PCN Participation Policy* (December 2017)** of the *PCN Policy Manual*. The *Zone PCN Participation Policy* was developed to provide guidance and set expectations for PCN participation and accountability within the PCN governance structure.

Zonal alignment of PCN Business Plans is a key component of supporting the outcomes of the PCN Governance Framework. Zonal alignment of PCNs will aid in evaluation of the process, identify opportunities for learning and improvement, and create a local supportive environment to build programs and services from a whole-zone perspective.

# Summary of PCN Key Information

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| **Name of the PCN:** | **Calgary West Central Primary Care Network** | | | |
| **Geographic Area:** | City of Calgary, south and west of the Bow River, north of Anderson Road and Tsuut'ina Nation. | | | |
| **Proposed Term of Plan:** | April 1, 2022, to March 31, 2025 | | **Provincial Legal Model:** | 1 |
| **Number of:** | **Clinics** | **Core Physicians** | **Panel # of Patients per Last Management Report from AH of** Oct. 1, 2021 | **Total Population in PCN area:** |
| **Participating in PCN** | 147 | 481 | | |
| **Within PCN Geographical Area** | (150) | (500) | 305,446 | 315,000 |
| **Total PCN Per Capita Funding** | Other Funding Sources | Total | Expenditures | Deficit/Surplus |

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| **Anticipated Direct Care Provider Staffing[1] (FTE) for Fully Implemented Plan:** | 59.9 |

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| 0 | Nurse Practitioners (NP)[2] | 0 | Dietitians | 0 | Respiratory Therapists |
| 2.8 | NPs in PCN NP Support Program | 0.8 | Pharmacists | 0 | Midwives |
| 31.5 | Registered Nurses | 0 | Physical Therapists | 0 | Occupational Therapists |
| 3.8 | Licensed Practical Nurses | 5.0 | Social Workers | 16.0 | Psychologists {"Other Licensed Provider"} |

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| **All Other Anticipated Staffing (FTE) for Fully Implemented Plan:** | 82.85 |

| **Clinical Support Staffing** | | **Administrative Staffing** | | **Support Staffing** | |
|---|---|---|---|---|---|
| 24.0 | Referral Coordinators | 0.4 | Medical Director[3] | 3.0 | IT |
| 5.75 | Medical Office Assistants | 1.0 | Executive Director[4] | 2.0 | Evaluation |
| 1.0 | Quality Improvement | 0 | All Other Mgt | 2.5 | Measurement |
| 3.0 | Clinical Management | 5.0 | Finance | | |
| 6.6 | Facilitator | 4.6 | Privacy & Policy | | |
| 3.0 | Clinical Coordinator | 5.0 | HR | | |
| 6.0 | Program Manager/Coordinator | 6.0 | Communications | | |
| | | 4.0 | Administrative Asst's {Other} | | |

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| **Anticipated Staffing (FTE) Total for Fully Implemented Plan:** | **142.5** |

**Priorities**

1. **Patient Medical Home**
2. **Community Services, Transitions, and Integrations**
3. **Member Services and Engagement**
4. **Governance and Central Allocations**

[1] Indicates staffing by designation, 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.
[2] NPs not funded under the PCN NP Support Program, i.e., not registered with the PCN or shadow billing.
[3] Document only the Full Time Equivalent (FTE) for the designated Medical Director role.
[4] Cannot exceed 1.0 FTE.

**Zone Service Plan Priorities that PCN Priorities are Aligned to:** (list only; do not describe alignment)

1. **To harmonize implementation of the Patient Medical Home by standardization of tools and resources across the zone.**
2. **To improve the continuous, personal relations to the Patient Medical Home by supporting strong transitions of care across the health system.**
3. **To establish robust governance, planning and operational structures.**

| **Governance Contact(s):** | **PCN** | **Physicians** | **Local AHS Rep** |
|---|---|---|---|
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# 1. Overview of Local Environment

| Priority Initiative | Element | Data Used to Inform Priority<br>(Data should highlight who needs this programming the most) | Data Source | Available Regional and Community Programming Already Serving This Population and Type of Programming Offered | Current Gaps in Service Provision or Challenges Related to Priority | Limitations of Data or Gaps in Information to Support Priority |
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| Patient Medical Home | • Patient Panel Program<br>• Patient Screening and Chronic Disease Management Planning Program | Southwest Calgary<br>• **Physician membership** is 481 family physicians, pediatric, and specialty services; 147 clinics; 60 per cent have a family practice plus seven per cent with family practice mixed with speciality practice.<br>• **Patient population** is 305,446; 53 per cent female; 43 per cent of patients between 35-64 and 14 per cent are 65 or older.<br>• Direct patient care through CWC PCN staff is available to 68 per cent of the patient panel (using 305,446 as denominator, which includes speciality, pediatric, and locum physicians). Most physicians with a family practice are choosing to access PMH support.<br>• Broad spectrum of socio-economic demographics ranging from substantially disadvantaged and homeless population located in Calgary's downtown core to patients living in the city's wealthiest communities.<br>• **The CWC PCN includes organizations dedicated to vulnerable and marginalized populations** including, for example, Calgary Urban Project Society (CUPS), the Alex Seniors Health Centre, and Elbow River Healing Lodge. | • Literature Review<br>• Contextual<br>• Qualitative<br>• Quantitative<br>• EMR data<br>• PCN profiles<br>• Community and PCN profiles<br>• Municipal stats<br>• Census<br>• HQCA Focus<br>• PCN operational data<br>• Physician and team consultation | • Mental health support is available in the community and through AHS depending on the level of need.<br>• The CWC PCN works with organizations to address duplication and/or streamline referral processes to ensure patient is seen by the right provider in a timely manner (e.g., Access Mental Health, Calgary Counseling Centre, Community Connect YYC).<br>• Diabetic foot care (community self-refer clinics)<br>• Chronic Pain clinic (AHS) | Mental health services — demand exceeds service available | • Community profile relies on outdated data<br>• HQCA data relies on proxy panel data<br>• HQCA data is outdated<br>• PCN profile data is outdated |

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| | | • The CWC PCN also borders the Tsuut'ina First Nation. Alberta Health estimates 1.3 per cent of the CWC PCN patient panel includes First Nations peoples.<br>**Health status — Disease:**<br>• Prevalence rates for the CWC PCN patient population are slightly lower than all other Alberta PCNs.<br>• Hypertension is 18.4 per cent (AB 20.8) per 100 population, followed by diabetes at 6.6 (AB 8.2).<br>• The burden of mental illness is estimated to be 21.3 per cent (in a lifetime) for Canadians. This translates to 64,590 patients within the CWC PCN panel. Anxiety and depression are the most common disorders.<br>**Regional and community resources:**<br>• The Rockyview General Hospital: full range of acute and outpatient care<br>• The Sheldon M. Chumir Centre provides 24/7 care for non-life-threatening injuries or illnesses, including urgent mental health care, diagnostic imaging, and laboratory.<br>**Health, population, and provider trends:**<br>• Increased demand for mental health support; virtual work environment key to recruitment and reduce staff turnover.<br>**Current issues, challenges, gaps:**<br>• Increased need for mental health support: demand outpaces limited CWC PCN resources.<br>• Decreased panel impacts level of funding to support patient care.<br>• Decreases in the average panel size of members reduces the level of service to members and patients (i.e., physicians join with panel 0-300 patients yet want full PMH team support). | | • Workshops/groups: groups offered through other PCNs (e.g., anxiety, lifestyle behaviours, healthy eating).<br>• Healthy Living (AHS)<br>• AHS Seniors Health<br>• AHS Home Care | | |

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| | | • COVID-19 priorities impact core PMH initiatives. | | | | |

## 1.1. Changes to Priority Initiatives and Elements from Last BPR

| Priority Initiative | Changes: Added (A) Enhanced (E) Discontinued (D) | Rationale for Changes | Risk/Mitigation Strategies related to changes to: HR Patient Safety, Legal and Liability Financial Health Info and Privacy Other |
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| **Patient Medical Home** — Mental Health Program | Added | An internal program was developed to provide greater consistency and stability in providing mental health support to physicians and their patients within the Patient Medical Home (PMH) through the deployment of Primary Care Registered Psychologists (PCRPs). PCRPs have a robust scope of practice and can treat a diverse array of complex mental health issues. The PCRPs have been deployed using a primarily virtual care model ensuring high levels of efficiency and maximizing patient access.<br>The Social Work team will move from the Community Services, Transitions, and Integration (CSTI) department to the PMH department to strengthen linkages and collaboration with the PCRPs and other aspects of the Mental Health Program. Social Workers assist CWC PCN patients and families address the impact of complex health issues and life stressors and then provide appropriate information, referrals, and assistance with patient access to supports and resources. Social Workers consider the social determinants of health, biopsychosocial and cultural needs of the patient, family, and their support systems, and assess community and other large system factors impacting patient health to support a patient's treatment and enhance their social well-being.<br>Furthermore, the CWC PCN has forged partnerships with community-based organizations that offer patients timely, affordable mental health issues services and supports. All physicians within the CWC PCN network can access these programs for their patients.<br>**Program staff include:**<br>• 14.0 FTE Primary Care Registered Psychologists<br>• 2.0 FTE Mental Health Referrals Professionals<br>• 1.0 FTE Mental Health Program Coordinator<br>• 1.0 FTE Mental Health Program Manager<br>• 5.0 FTE Social Workers | **HR**<br>• Recruitment and retention of a sufficient number of PCRPs and Social Workers to fulfil PCN needs<br>**Other**<br>• Ensuring that staff work in alignment with other members of the PMH team, including physicians |

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| **Member Services and Engagement –** Community-Based Supports Program | Added | This program will work to build and sustain tactical partnerships that facilitate physician and patient access to community-based programs and services. Local, provincial, and national organizations will be the target of these partnership-building efforts. These partnerships will ensure that physicians and patients have seamless access to community-based programs and services and enhance the timeliness and effectiveness of care provided. Furthermore, this program will ensure that the CWC PCN avoids program and service duplication and builds strong and sustainable care pathways that consistently meet physician and patients needs.<br>**Program staff include:**<br>• 2.0 FTE Community Integration Consultants | **Health Info and Privacy**<br>• Access to reliable data that accurate reflects the needs of physicians and their patients in relation to community-based programs and services<br>**Other**<br>• Environmental pressures and changes triggering new physician and patient needs<br>• Stable and consistent leadership and staffing within partner organizations |
| **Member Services and Engagement —** Clinic Engagement Program | Added | This program will engage clinic managers and staff to ensure that they are active, supportive partners in the development of PMHs. To facilitate engagement, the following activities will be carried out:<br>• Annual evaluation to assess level of understanding of PMH and CWC PCN programs and services and identify gaps<br>• Develop tactics to improve clinic manager/staff understanding<br>• Develop a Clinic Manager Champions group<br>• Educational sessions for clinic managers/staff to improve understanding of PMH and other programs/services<br>• Communications strategy and tactics specifically for clinic managers and staff<br>This will create greater alignment between clinics and physicians with the CWC PCN's approach to PMH.<br>**Program staff include:**<br>• 2.6 FTE Physician Liaisons<br>• 1.0 FTE Physician Liaison Lead<br>• 1.0 FTE Community Integration Consultant | **Other**<br>• Limited time, interest, and availability of clinic managers and staff to actively engage with the CWC PCN |

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| **Governance and Central Allocations —** Fund Development and Diversification | Added | The CWC PCN is working on a series of strategic fund development initiatives including, but not limited to, social enterprise funding, charitable funding, and acquiring grants (federal, provincial, corporate) that align with its Ends policies and the Alberta Health objectives for primary care. All funding will contribute to the CWC PCN's ability to deliver innovative programs and increase health equity and positive health outcomes for patients in our catchment area. The fund diversification strategy will help diversify the CWC PCN's revenue, assist our primary funder (Alberta Health), and allow the organization to sustainably expand its clinical services and programs, especially as they relate to resources for vulnerable populations.<br>**Program staff include:**<br>• 0.6 FTE Grant/Fund Development Administrator | **Financial**<br>• Ensure prospective grants align with organizational objectives and can fund core programs<br>**Other**<br>• Ensure all prospective grants align with AH provincial objectives and come from reputable organizations or entities |
| **Governance and Central Allocations —** Organizational Effectiveness through Administrative Working Groups | Added | The CWC PCN's Governance & Organizational Operations (G&O) department will develop a strategy to audit all CWC PCN administrative working groups including, but not limited to, patient safety, data governance, employee engagement, occupational health, and safety committees. Under the audit strategy, G&O will audit and assess working group mandates and terms of reference and develop a working framework to ensure all working groups understand their goals and can achieve the required deliverables subject to regular evaluation.<br>The CWC PCN will develop new employee and physician advisory groups similar to the current Patient Advisory Council. New terms of reference will be drafted for all three along with a detailed calendar of activities and outcomes to ensure feedback on programming and operational initiatives is received from all key stakeholders. These groups will develop an integrated quality improvement framework to identify quality improvement opportunities.<br>**Program staff include:**<br>• 1.0 FTE Governance and Policy Lead<br>• 1.0 FTE Board Governance Coordinator<br>• 1.0 FTE Policies and Procedures Coordinator<br>• Representation from stakeholders across the organization, including the Medical Director and patients. | **Other**<br>• Regularly reviewing and overseeing the mandates and practices of these groups helps ensure there is no duplication of work, that established goals are timely and measurable, and that employees are empowered to work collaboratively |

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| **Governance and Central Allocations —** Collaborative Patient Safety Strategy | Added | As part of the CWC PCN's commitment to ensuring a safe care environment that is free of abuse, the G&O department will jointly develop a strategy with the PMH and CSTI departments that supports employees in recognizing and preventing the abuse of patients. The strategy will represent the organization's existing health, safety, and welfare policies and provide a basic and practical approach for employees across the organization to recognize when patients may be at risk for abuse, what the type of patient abuse is, and understand what safeguards are in place across the organization. The launch of this strategy will be accompanied by organization-wide learning and resource sharing.<br>An organization-wide approach to recognizing and preventing patient abuse will provide the organization with a shared understanding of the implications of patient abuse on the treatment of patients and families and patient outcomes at CWC PCN-managed clinics.<br>**Program Staff Include:**<br>• 1.0 FTE Governance and Policy Lead<br>• 1.0 FTE Policies and Procedures Coordinator | |
| **Zonal Service Plan** — Zone Service Plan Support Program | Added | The CWC PCN is committed to actively collaborating with local partner PCNs to build and implement the Calgary Zone Service Plan. This is accomplished through consistent discussions with PCN partners and a dedicated investment of time and in-kind resources for initiatives included in the Calgary Zone Service Plan. The CWC PCN plays a role in all Calgary Zone planning and implementation structures, including zonal committees and working groups.<br>**Program staff include:**<br>• (Shared with the Community Integration Program)<br>• 2.0 FTE Community Integration Consultants<br>**What this will achieve:**<br>Collaboration with Calgary-and-area PCNs will ensure the CWC PCN plays a pivotal role in joint service planning and addressing primary care needs for priority areas across the zone. | **HR**<br>• Adequate staffing to support Calgary Zone initiatives<br>**Financial**<br>• Adequate financial resources to contribute to the Zone Business Unit's operations and all Calgary Zone Service Plan initiatives |

# 2. Priority Initiatives

## 2.1. Summary of Comparative Information by Provincial Objective

- Within the table below, indicate how the PCN adopts the provincial objectives:

1. **Accountable and Effective Governance:** Establish clear and effective governance roles, structures, and processes that support shared accountability and the evolution of primary healthcare delivery.
2. **Strong Partnerships and Transitions of Care:** Coordinate, integrate, and collaborate with health services and other social services across the continuum of care.
3. **Health Needs of the Community and Population:** Plan service delivery on high quality assessments of the community's needs through community engagement and assessment of appropriate evidence.
4. **Patient Medical Home:** Implement Patient Medical Home to ensure Albertans have access to the right services through the establishment of interdisciplinary teams that provide comprehensive care.

## 2.2. Priority Initiatives: Patient Medical Home (PMH)

**Risks and Mitigating Activities Associated with Patient Medical Home**
**Priority Initiatives including the programming your PCN offers in support of a Zone Service Plan Priority Initiative.**

These priorities address the pillars of PMH including appropriate infrastructure, connected care, accessible care, community adaptiveness and social accountability, comprehensive team-based care with physician leadership, continuity of care, patient- and family-centred care, measurement, and continuous quality improvement and research.

The CWC PCN seeks to support members in building and sustaining high quality PMHs for their patients. Physician support is built on the best available evidence including recommendations from the College of Family Physicians of Canada: The Patient's Medical Home 2019 and Chronic Care Management in a Patient's Medical Home, June 2016. These recommendations are consistent with the Agency for Healthcare Research and Quality (AHRQ) where high quality primary care includes: "supportive leadership; a quality improvement strategy including helpful information systems and data; defined patient panels; and skilled team-based care provision." AHRQ further indicates: "this infrastructure equips primary care providers with the competencies to: use data to continuously monitor and improve quality; use clinical data to identify care gaps and plan visits; reach out to patients with gaps in care to remedy them; and proactively link patients and providers together to support continuity of care." The CWC PCN uses an integrated framework of population health and chronic disease management in its approach to supporting the PMH[5]. Patient care includes early detection through screening (as recommend through the Alberta Screening and Prevention Program[6]), chronic disease management, and support and treatment for mental health conditions that can be managed in primary care. Program development toward PMH is guided using population data and integrated population health and chronic disease management principles and concepts.

[5] The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. (2003). Barr, V.J., Robinson, S., Marin-Link, B., Underhill, L., Dotts, A., Ravensdale, D., and Salivaras, S.. https://www.longwoods.com/content/16763/healthcare-quarterly/the-expanded-chronic-care-model-an-integration-of-concepts-and-strategies-from-population-health-pr.
[6] https://actt.albertadoctors.org/PMH/organized-evidence-based-care/asap/Pages/default.aspx.

| Priority | Element | Service Scope Description | How it Aligns to PCN Objectives | How it Aligns to ZSP Objectives (Alignment, Integration, Shared Services) | How Does it Align to ZSP Priorities? Which Ones? | Service Responsibility Addressed |
|---|---|---|---|---|---|---|
| PMH | Patient Panel Program | **Goal:**<br>Physicians are supported to panel their patients and implement an ongoing patient validation process. This includes supporting physicians to participate in the provincially mandated CII/CPAR strategy.<br>**How:**<br>Physicians are supported to maximize the efficiency and effectiveness of their electronic medical record (EMR) so that it can be used to manage patient panels and support patient validation processes. The CII/CPAR readiness checklist is used for confirming panel readiness. This includes a patient validation process and preparing the physician's panel for CII/CPAR participation.<br>**Program staff include:**<br>• 10.0 FTE of Health Information Coordinators (HIC): create extractions, set alerts in EMRs, and support physicians with process including paperwork and submitting data to CII/CPAR<br>• HICs support physician members virtually and have remote access to EMRs.<br>• 1.0 FTE Quality Improvement Consultant<br>**What this will achieve:**<br>• Patient population identification will create a cohesive understanding of the composition and make-up of populations at physician, clinic, and PCN level.<br>• Decision support to physicians using EMR information.<br>• CII/CPAR participation supports the communication about patient care in EMRs. | Patient Medical Home | Alignment | Patient Medical Home | • Chronic screening/ prevention<br>• Information management |
| PMH | Patient Screening and Chronic Disease Management | **Goal:**<br>Ensure patients receive coordinated, evidence-informed care within the Patient Medical Home, with an emphasis on screening and chronic disease management. | Patient Medical Home | Alignment | Patient Medical Home | • Complex care<br>• Chronic screening/ prevention |

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| | Planning Program | **How:**<br>• Led by the physicians, improvement goals are driven by the patient population and gaps in patient management (e.g., best practice for managing specific health conditions). Clinical decision support tools (e.g., electronic visit templates and forms) provide best practice guidelines for patient care and, where gaps are identified, improvement plans are developed and implemented.<br>• HICs facilitate the team to implement improvement goals, manage improvement projects (with the support of the Quality Improvement Consultant), and extract EMR data required for improvement work.<br>• Patient Care Coordinators (PCCs) support physicians and allied health clinicians in booking patients for appointments and providing patients with information such as screening opportunities.<br>• PCCs and HICs work together in a paired model.<br>• Utilize project management tools to support improvement projects and ensure team communication for the physician and PMH team.<br>• EMR training is offered to physicians as relevant to PMH work (for major EMRs or as identified by the membership).<br>• Teams identify opportunities for consistency and spread across clinics where appropriate.<br>**Program staff include:**<br>• 10.0 FTE HICs: facilitate and guide the development of improvement goals<br>• HICs have a health information management certification and have ongoing training in quality improvement, group facilitation, and project management. HICs are assigned to physicians/clinics as part of the PMH team and facilitate the implementation of PMH improvement goals.<br>• 18.0 FTE PCCs: support the physician and care teams with care coordination<br>PCCs typically have medical office assistant training.<br>• 1.0 FTE EMR Project Lead<br>• 1.0 FTE Quality Improvement Consultant: provides support to the HICs and PMH teams to build improvement capacity within the PMH and across the organization | | | | • Population health |

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| | | • Physicians and teams are facilitated to develop improvement goals to better manage patient care.<br>• Patients receive the right care at the right time from the right provider. | | | | |
| PMH | Patient Screening and Chronic Disease Management Delivery Program | **Goal:**<br>Patients are provided care within the PMH. PMH teams provide patient-centred, comprehensive, coordinated, team-based care. This approach uses clinical decision support tools to guide best practice, evaluation, quality improvement, comprehensive training, and education to improve the care provided to patients to enhance access and improve patient outcomes.<br>**How:**<br>• The CWC PCN considers factors such as panel, patient population, and burden of disease to determine PMH resources.<br>• Patient care is delivered according to care plans for groups of patients where possible (as identified by team PMH improvement goals).<br>• Within family practices, patient care delivered by allied health professionals is provided through digital health technologies and in-person appointments (in clinic) based on patient need and patient preference.<br>• Clinical decision support tools are used to support consistent evidence-formed care.<br>• Patient-directed self-management virtual options are available to all patients within the CWC PCN (e.g., education videos, pamphlets, self-directed therapy, etc.). Where possible, materials are made available to patients who do not have access to digital options.<br>• Clinicians receive an orientation to the PMH including team-based care, use of improvement methodology, and use of data to inform teams about care processes and patient outcomes.<br>• Professional development and ongoing training are used to ensure staff continue to deliver consistent high-quality care.<br>• Ongoing mentoring by colleagues and management as well as a community of practice is available to staff. | • Strong Partnerships and Transitions of Care<br>• Health Needs of the Community and Population<br>• Patient Medical Home | Alignment | Patient Medical Home | • Complex care<br>• Psychological Counselling<br>• Chronic screening/ prevention<br>• Population health |

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| | | • The CWC PCN will develop and implement an internal referral program for CWC PCN clinicians. This will ensure that a patient sees the most appropriate provider. Referral within teams can be made if it is in the best interest of the patient.<br>• Utilization of a patient-initiated booking system to enhance access to patients. Where patients do not have access to digital technology, a centralized telephone number will be implemented if the patient does not want to access services through their family physician. Patient-initiated appointments are available in clinic as appropriate.<br>**Program staff include:**<br>• 26.0 FTE Primary Care Registered Nurses with diverse skillsets to ensure appropriate matching to patient needs within physician practices (e.g., certified diabetes educators, mental health training, healthy equity, maternity, etc.).<br>**What will this achieve:**<br>• Integrated teams will meet the comprehensive healthcare needs of patients.<br>• Patient-centred interventions that optimize population engagement consistent with preferences and values and focuses resources on appropriate population cohorts.<br>• Integrated, collaborative teams in an environment that supports informational and interprofessional continuity.<br>• Improved management and health outcomes of patients with chronic disease<br>• Improved access for patients within the medical home<br>• High quality, evidence-informed care | | | | |

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| PMH | Patient Outcome Measurement Program | **Goal:**<br>Evaluation and continuous quality improvement:<br>The CWC PCN uses a data-driven, continuous quality improvement approach that is based on the best available evidence to support the transition of family practices to PMHs. Physician-led improvement goals are driven by population need and best practice for early detection and mental health and chronic disease management.<br>Patients are involved in improvement processes to ensure care is provided in accordance with patients' wants and needs. Evaluation of the transition to PMH is conducted on an annual basis.<br>**How:**<br>• Data is collected through regular and ad hoc data extractions from EMRs, patient experience measures, patient reported outcome measures, and provider surveys.<br>a) Quarterly data extractions support a standard set of improvement reporting.<br>b) Patient reported outcomes and experience information are collected and monitored for change over time.<br>c) EMR data used to look at patient outcomes over time, including management of patients according to best practice and changes in biometric data relevant to targets.<br>d) Staff utilization tracking is used to monitor daily patient encounters, proportion of direct versus indirect patient care, as well as compliance with the use of decision support tools.<br>e) Utilize dashboard software to improve data management and efficiencies for timely reporting.<br>**Program staff include:**<br>• 3.0 FTE Evaluation staff that support evaluation and operational reporting.<br>• 2.5 FTE Measurement and Analytics staff to support data management, create systematic improvement, and operational reporting using visualization software (tableau); create ad hoc improvement reporting and provide ad hoc reporting across the organization.<br>• The roles to support this program include staff with specialized training in evaluation, measurement, analytics, data management, and visualization software. | Patient Medical Home | Alignment | Patient Medical Home | • Chronic screening/ prevention<br>• Population health |

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| | | **What will this achieve:**<br>• Timely information to inform the improvement goals of the physician's practice.<br>• Risk stratification to identify cost drivers and patients at risk and to help define interventions required to support population and segments.<br>• Health assessments to drive organizational strategy and allocation of resources to support identified population.<br>• An understanding of how this model of PMH impacts patients and providers (e.g., cost analysis).<br>• Monitoring of patient outcomes at both the individual physician level and the PCN level (for Board and provincial reporting) to support business planning processes.<br>• Monitor transition of physicians with a family practice toward building PMHs.<br>• Staff within this team provide support for measurement, analytics, reporting, and evaluation across the organization. | | | | |
| PMH | Management of Program | Management staff will oversee the strategic direction and program delivery of the Patient Medical Home support to member physicians.<br>• 1.0 FTE Director, PMH<br>• 1.0 FTE Manager, PMH Coordinators<br>• 1.0 FTE Manager, Screening and Chronic Disease Management<br>• 1.0 FTE Manager, Mental Health Program<br>• 1.0 FTE Assistant Manager and Project Lead<br>• 1.0 FTE PMH Project Coordinator<br>Additional program staff include periodic consultants to provide temporary specialized knowledge and skills to support program planning and implementation. | Patient Medical Home | Alignment | Patient Medical Home | • Complex care<br>• Psychological Counselling<br>• Chronic screening/ prevention<br>• Population health |
| PMH | Linkages | The CWC PCN has established several community partnerships and linkages to support patient care. Examples of these partnerships include:<br>• Access Mental Health: Enables more streamlined referral to community services for physicians and their patients.<br>• Canadian Mental Health Association (CMHA): The CWC PCN works collaboratively to provide group sessions for patients. | • Strong Partnerships and Transitions of Care | Integration | Patient Medical Home | • Complex care<br>• Psychological Counselling<br>• Chronic screening/ prevention |

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| | | • Community Connect YYC: Providing patients with mental health issues access to free or low-cost services from more than a dozen community-based organizations with expertise in mental health service delivery.<br>• Health Quality Council of Alberta (HQCA): Physicians are supported to share data with the HQCA so they can understand system use by their patient panel. The HQCA provides some system information at the PCN level on an annual basis.<br>• Institute of Health Economics: Work collaboratively to understand system impact of PMH model on patient outcomes. | • Health Needs of the Community and Population | | | • Population health<br>• Information management |
| PMH Zonal | Patient Medical Home Task Group | The PMH Task Group will identify strategies that help physicians and their teams build and sustain their PMHs. The PMH Task Group will also support the planning and implementation of these strategies. The PMH Task Group will utilize a working group structure to accomplish these tasks. The three working groups are:<br>1. Foundations: Infrastructure, connectivity, paneling, and CII/CPAR<br>2. Functions: Access, clinical guideline informed patient and family centred care, continuity of care, and comprehensive team-based care<br>3. Ongoing Development: Patient outcome measurement, continuous improvement, research, training, and education | • Strong Partnerships and Transitions of Care<br>• Health Needs of the Community and Population | Integration | Patient Medical Home | • Complex care<br>• Chronic screening/ prevention<br>• Population health |
| PMH Zonal | Specialist Integration Task Group | Zone program designed to simplify access to specialty care by primary care providers (PCP); support PCP to manage their patients in the medical home; develop mutually agreed upon referral pathways; improve wait times for patients accessing specialty care; and improve communications between primary care and specialty care.<br>There are three areas of activity:<br>1. Specialist Link: A real-time telephone non-urgent advice line connecting PCP and specialists.<br>2. Enhanced Primary Care Pathways or clinical pathways<br>3. Access pathways: Simplified one-page, quick reference guides for some specialty groups that are complicated and difficult for family physicians to navigate. | • Strong Partnerships and Transitions of Care<br>• Health Needs of the Community and Population<br>• Patient Medical Home | Integration | Patient Medical Home | • Complex care<br>• Population health |

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| | | These decision support tools and resources are built through collaborative efforts between PCP and specialists and are available to primary care team members/colleagues. | | | | |

| Description of Risk | Zone PCN Service Plan Priority Initiative | Activities to Mitigate/Prevent the Risk from Occurring | Strategies to Address the Risk Should it Occur |
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| Members not engaging in paneling and not adopting CII/CPAR. | • Patient Medical Home: To harmonize implementation of the PMH by standardization of tools and resources across the zone | • Supporting physicians with dedicated resources to implement the program<br>• Reducing barriers to physicians engaging in the program<br>• Implementing a physician champion group that can support and facilitate late adopters to see the benefits of the program | • Ongoing physician education and support about the benefits of the program. |
| Members not fully adopting PMH way of working. | • Patient Medical Home: To harmonize implementation of the PMH by standardization of tools and resources across the zone | • A formal membership evaluation, implemented annually, monitors how member medical homes are maturing. Annual measurement provides feedback about progress and identifies potential improvement strategies that the PMH team may undertake to further build sustainable medical homes. Annual measurement also provides feedback to members as part of ensuring they are meeting the expectations of Enhanced and Comprehensive membership.<br>• Development of a community of practice for members to share successes and lessons learned in building PMHs | • Evaluation framework<br>• Ongoing physician engagement<br>• Ongoing physician education |
| Attracting and retaining quality of resources to meet the needs of the program | • Overarching implementation: To establish robust governance, planning, and operational structures | • Offer innovative and interesting work<br>• Competitive salaries and benefits packages<br>• Conduct annual employee engagement survey and an external market survey on employee compensation equity every three years | Recruitment<br>• Employee retention strategies<br>• Strengthen employee engagement and connection |
| Privacy and security of information | • Overarching implementation: To establish robust governance, planning, and operational structures | • Restrict access and management of data to a limited set of people who have a business need to do so | • Instances of noncompliance with privacy policies and procedures are documented and reported<br>• Learning/training and/or disciplinary measures in place |

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| | | • Staff handling identifiable patient data will undergo additional training to ensure they understand the risks and their responsibilities to protect the information.<br>• IT infrastructures and processes that reduce risk<br>• The CWC PCN employs a 1.0 FTE Privacy Governance Advisor and works with an external privacy consultant.<br>• Secure encryption of all data and information housed by the CWC PCN | • Notification is given immediately in writing to the OIPC, Minister of Health and to the affected individuals |
| Patients lacking awareness of PMH and the importance of attachment to a family physician for continuity of care. | • Patient Medical Home: To harmonize implementation of the PMH by standardization of tools and resources across the zone | • Education of patients through a patient newsletter<br>• Continue to work with the Calgary Zone Communications Working Group to develop strategies to raise awareness of PMH among patients | • Communication strategy with clinics and providers and patients |
| Inequity of patient access based on physician membership type | • Patient Medical Home: To harmonize implementation of the PMH by standardization of tools and resources across the zone | • Working with physician members to identify appropriate resources for appropriate patient populations<br>• Partnerships with external providers that are available at no cost to patients and all physician members can refer | • Ongoing collaboration and innovation to develop strategies to improve access for these patients |

### 2.2.1. Implementation Timeline

| Time Period | Key Activities | Deadlines, Goals and Comments |
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| April 2022 – March 2023 | Supporting physician members with conformed EMRs to complete their panel validation and maintenance process and to successful onboard to CII/CPAR. | The provincial and Calgary Zone goal for this initiative is to have 80 per cent of physicians with a conformed EMR paneled and onboarded to CII/CPAR by March 31, 2023. The CWC PCN will work to ensure that it achieves this goal by the target date. |
| April 2022 – December 2022 | Test and implement clinical decision support tools designed to help members of the PMH team provide care and support that aligns with the most up-to-date clinical practice guidelines for all ASaP screening maneuvers and core chronic diseases. | Have all PMHs with teams implement clinical decision support tools by Dec. 31, 2022. Once implemented, use the data generated using these tools to assess the impact of PMH teams on patient outcomes. |
| April 2022 – March 2025 | Implement screening and chronic disease programs to provide patients with optimal care within the PMH. | Maximize the number of patients who are able to access the screening and chronic disease management supports available to them within the PMH and measure the impact of the care delivered on patient outcomes. |
| April 2022 – March 2025 | Continuously improve and strengthen the volume and quality of mental health services and supports available to physician members and their patients. | Streamline access to mental health services within the CWC PCN and the community at large and maximize the number of patients with mental health concerns who can obtain timely and effective care. |
| April 2022 – March 2025 | Build alignment within the Calgary Zone when it comes to the services offered within the PMH, how these services are delivered, and how the outcomes of these services are measured. | Build a strategy that is fully endorsed by leadership within all Calgary Zone PCNs and Calgary Zone leadership and systematically plan, implement, and complete projects that increase high-impact care and measurement within the PMH. |

## 2.3. Priority Initiatives: Community Services Transitions and Integrations (CSTI)

**Risks and Mitigating Activities Associated with Community Services, Transitions, and Integrations**
**Priority Initiatives including the programming your PCN offers in support of a Zone Service Plan Priority Initiative.**

The CWC PCN has a dedicated CSTI team. The primary goal of this team is to systematically identify and eliminate barriers that prevent physicians and patients from accessing health and mental health interventions and treatments that cannot be performed within the PMH. This identification occurs through regular consultation with physicians, allied health professionals, and patients. Elimination of barriers will be achieved through the development of practical strategies and workflows that facilitate patient transitions between the PMH and community-based programs and services. By identifying and eliminating these barriers, physicians and patients will gain access to care in a timely and efficient manner, minimizing the likelihood that patients' health will deteriorate and require more intensive ambulatory, urgent, or emergency care. Barriers and gaps in care are always at the forefront of the team's decision-making when it comes to determining which partnerships to build, nurture, and sustain. The team operates using a partnership model built on reciprocal exchange and value to maximize the utility of the collaborative efforts invested by the CWC PCN and all collaborating, partner organizations. Ultimately, the team hopes to weave tighter connections between the PMH and programs and services available in the community. By doing so, the burden that physicians encounter when attempting to coordinate care will be significantly reduced and patients' health outcomes will improve.

| Priority | Element | Service Scope Description | How it Aligns to PCN Objectives | How it Aligns to ZSP Objectives (Alignment, Integration, Shared Services) | How Does it Align to ZSP Priorities? Which Ones? | Service Responsibility Addressed |
|---|---|---|---|---|---|---|
| CSTI | Primary Care Centre | **Goal:**<br>• To provide physicians and patients a central access point to primary care 365 days a year.<br>**How:**<br>• The Primary Care Centre service is available for both physician members' patients and unattached patients residing in the primary service area during regular business hours and as an afterhours support. Patient access to services is maximized by providing care in person and virtually using digital health technology. The Primary Care Centre is designed to support the provision of continuous, comprehensive primary care by physician members within the PMH. Referrals are received from both CWC PCN physician members and Health Link.<br>  • A 24-hour Blood Pressure Monitoring program is operated out of the Primary Care Centre and is accessed by referral.<br>  • An after-hours call service provides patients with coverage for urgent health issues and critical lab follow-up on weekends and holidays and when members' offices and the Primary Care Centre are closed.<br>• The Primary Care Centre works collaboratively with the other Calgary Zone PCN access clinics, offering increased access to appointments and balancing referral volume. Patients can select their preferred access clinic location at time of referral and booking. | Patient Medical Home | • Alignment<br>• Integration | Patient Medical Home | • Basic ambulatory care<br>• Chronic screening/ prevention<br>• Population health<br>• 24/7 management of access<br>• Lab and D/I access<br>• Unattached patients |

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| | | **Acute Care Referrals:** The Primary Care Centre collaborates with the Rockyview General Hospital (RGH) Emergency Department (ED) to provide a redirection service for patients presenting at the ED with low acuity CTAS scores. In addition to the direct referrals from RGH, a collaboration with Mayfair Diagnostics enables patients to be referred from RGH ED to Mayfair and then to the Primary Care Centre for physician review of DI results and communication back to the family physician. Patients discharged from RGH ED can also be referred by the ED physician for follow-up at the Primary Care Centre if they are either unattached or unable to be seen by their family physician/medical home.<br>• Unattached patients are also directed to the Primary Care Centre for follow-up via the Enhanced Hospital Discharge Program, which covers various units at all four Calgary Zone urban acute care sites. As with all unattached patients seen at the clinic, patients are supported in attaching to a family physician.<br>**Program staff include:**<br>• The care team is comprised of CWC PCN physician members supported by:<br>  • 2.0 FTE LPN plus casuals<br>  • 4.0 FTE MOA plus casuals<br>  • 1.0 FTE clinic coordinator<br>Physicians are paid on an hourly rate, with FFS costs recovered by the CWC PCN from AH as able.<br>**What this will achieve:**<br>• Physician members supported by the provision of out-of-hours primary care service for their patients.<br>• Patients of CWC PCN members and unattached patients within the CWC PCN's boundaries have access to essential primary care services 365 days/year. | | | | |

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| CSTI | Health Equity Program | **Goal:**<br>• To support the provision of comprehensive family practice at clinics within the CWC PCN catchment area that serve unique patient populations using a health equity lens, including Indigenous peoples. These clinics are as follows:<br>  • The Tsuut'ina Primary Care Clinic, Elbow River Healing Lodge, CUPS, and The Alex, including Alex Youth and Alex Seniors.<br>**How:**<br>• Supporting the operations of the clinics through the provision of financial resources to hire allied health professionals with the knowledge, skills, and experiences necessary to effectively support patients living in vulnerable conditions.<br>**Program staff include:**<br>• Funding is allocated to clinics to enable them to hire the allied health professionals and administrative staff necessary to support the delivery of effective, health equity informed care and purchase essential clinical tools (i.e., EMR, lab services, clinic supplies).<br>**What this will achieve:**<br>• Clinics are supported in their ability to provide comprehensive family practice to their patients.<br>• Support for new and emerging primary care needs of the community to be addressed quickly and efficiently. | • Strong Partnerships and Transitions of Care<br>• Health Needs of the Community and Population<br>• Patient Medical Home | Alignment | Patient Medical Home | • Complex care<br>• Chronic screening/ prevention<br>• Population health |
| CSTI | Senior Services Program | **Goal:**<br>• To provide specialized primary care with the goal of supporting seniors to remain in their homes and communities for as long as possible. | • Strong Partnerships and Transitions of Care<br>• Health Needs of the Community and Population | • Alignment<br>• Integration | • Patient Medical Home<br>• Supported Transitions | • Complex care<br>• Geriatric care<br>• Population health |

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| | | **How:**<br>• Services are provided by a multidisciplinary team to patients in their own homes, at the Primary Care Centre, and in physician member clinics. Access is by referral and available to seniors attached to CWC PCN members.<br>• The physicians on the team provide patient consultations at either the Primary Care Centre or through home visits. Physician payments are covered by CWC PCN at an hourly rate of which the fee for service component is recovered by Alberta Health.<br>• Geriatric psychiatrists work within our Senior Services Program seeing patients aged 60-plus referred from CWC PCN physician members. They support patients with complex mental health issues, medication concerns, and those needing diagnostic clarity. In addition, there is one neurologist who joins patient rounds every six weeks to support consults from the Senior Services team for patients that require additional diagnostic clarity. These roles direct bill to Alberta Health.<br>• The physician lead custodian undertakes responsibility for the Clinical Program EMR. This includes reviewing and approving requests for release of health information. Additional responsibilities include: the responsibility as custodian for Netcare for the CWC PCN Clinical Program and collaboration with the CWC PCN's Privacy Officer to review and follow-up on reports of privacy breaches.<br>**Program staff include:**<br>• Physicians with a special interest in care of the elderly<br>• 1.0 FTE RN<br>• 1.0 FTE LPN<br>• 5.4 FTE Senior Services Registered Nurses<br>• 0.8 FTE Pharmacist<br>• 1.0 FTE MOA<br>• 1.0 FTE Clinic Coordinator | • Patient Medical Home | | | |

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| | | **What this will achieve:**<br>• Physician members supported in the provision of care to their seniors with complex needs.<br>• Patients receiving the support they need to continue living at home and in their community for as long as possible.<br>• Connection to supports and resources for caregivers. | | | | |
| CSTI Zonal | Supported Transitions Task Group | This task group is dedicated to creating an effective process and communication between acute care and primary care.<br>Key groups that report to the task group are:<br>1. Find a Doc Website: The Find a Doc website originated in the Calgary Zone and has grown to be a provincial initiative. It is integral to supporting attachment of patients to PCN physician members.<br>2. Home to Hospital to Home (H2H2H) Transitions: A shared AHS and PCN priority that aims to support informational, relational, and management continuity between patients and their family physician in a medical home. These resources are critical to the success of implementation of H2H2H guideline.<br>**Program staff include:**<br>• 2.0 FTE Community Integration Consultants | • Strong Partnerships and Transitions of Care<br>• Health Needs of the Community and Population<br>• Patient Medical Home | • Alignment<br>• Integration | • Patient Medical Home<br>• Supported Transitions | • Complex care<br>• Geriatric care<br>• Population health<br>• Chronic screening/ prevention |
| CSTI | Mgmt. of Program | Three FTE management staff will oversee this program over the next three years:<br>• 1.0 FTE Director of CSTI<br>• 1.0 FTE Manager of Clinic Operations<br>• 1.0 FTE Assistant Manager of Clinic Operations | • Strong Partnerships and Transitions of Care<br>• Health Needs of the Community and Population | • Alignment<br>• Integration | • Patient Medical Home<br>• Supported Transitions | • Complex care<br>• Geriatric care<br>• Population health<br>• Chronic screening/ prevention |

| Description of Risk | Zone PCN Service Plan Priority Initiative | Activities to Mitigate/Prevent the Risk from Occurring | Strategies to Address the Risk Should it Occur |
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| Community partners managing competing priorities and unable to engage in collaboration with the CWC PCN. | • Strong Partnerships and Transitions of Care<br>• Patient Medical Home | • Regular communication with partners to identify timing of collaboration<br>• Understanding of partners priorities and seeking alignment with CWC PCN priorities<br>• Patience with collaboration, so as not to disengage potential partners from future collaboration opportunities | • Exploration of alternate partnerships to address gaps in care |
| Attracting and retaining skilled employees to meet program needs | • Strong Partnerships and Transitions of Care<br>• Patient Medical Home | • Offer innovative and interesting work<br>• Competitive salaries and benefits packages | • Innovative recruitment strategies |
| Conflicting feedback from physician members regarding gaps in care | • Strong Partnerships and Transitions of Care<br>• Patient Medical Home | • Annual needs assessments with sample of physician members and clinical teams<br>• Environmental scans to verify information regarding gaps in care | • More extensive consultation with membership |

## 2.3.1. Implementation Timeline

| Time Period | Key Activities | Deadlines, Goals and Comments |
|---|---|---|
| April 2022 – March 2025 | Provide physician members and patients with access to primary care services 365 days per year, emphasizing access for patients when their PMH is unavailable after hours and on weekends. | Ensure that the Primary Care Centre is available to all CWC PCN physicians and patients 365 days per year for the duration of the business plan. |
| April 2022 – September 2022 | Collaborate with clinics that primarily serve and support patients with vulnerabilities using a health equity lens. | Transition from staffing clinics that primarily serve and support patients with vulnerabilities with CWC PCN PMH team members to providing the resources required for these clinics to hire their own staff. |
| April 2022 – December 2022 | Strengthen the services provided to seniors and ensure physician members have access to services so that these patients are able to live as independently in the community as possible. | Assess the current seniors' services provided and continuously improve these services to ensure that they align with physician members' needs and seniors' needs. |
| April 2022 – March 2025 | Continuously appraise the health and social services available to physician members and patients within the community and build functional linkages to support fluid, seamless transitions of care between these programs and patients' PMHs. | Identify what community-based services physician members and patients require consistent access and/or services where access and transitions have historically been challenging and build pathways and processes to facilitate integration between these services and the PMH. |

# 2.4. Priority Initiatives: Member Services and Engagement (MSE)

**Risks and Mitigating Activities Associated with Member Services and Engagement**
**Priority Initiatives including the programming your PCN offers in support of a Zone Service Plan Priority Initiative.**

Governance of our membership ensures physician members are informed, engaged, and participate in the advancement of professional excellence for themselves, their patients, and their network. The team strives to understand the needs of the diverse membership and develop solutions that add value and help physicians in their practice. Through regular contact with physicians and clinics and effective communication and marketing tools, the Member Services & Engagement (MSE) team ensures physicians are informed of the PCN services and resources available to support their practice and their patients. The MSE team regularly asks members for, and gathers feedback to support, continuous improvement and the identification of innovative solutions to ensure they are satisfied and happy with their work lives and able to provide quality care to their patients. MSE programs, services, and projects are aligned with the Membership ends policies and support the following goals:

- Customer service: To provide effective and responsive support to members' inquiries and concerns.
- Communications: To provide streamlined, effective, and timely two-way communication with members to support their understanding of PCN programs and services and to provide flexible and up-to-date resources and tools that correspond to the diverse physician needs.
- Engagement: To ensure member involvement in improving current and shaping future programs.
- Board governance: To facilitate members' understanding of Board governance.
- Primary care partners: To understand the primary care landscape through effective and strategic relationships.

While MSE priority programs have changed very little since the 2019-22 business plan, work will focus on deepening engagement with members and leveraging engagement data to support decision-making and implementing improvements.

| Priority | Element | Service Scope Description | How it Aligns to PCN Objectives | How it Aligns to ZSP Objectives (Alignment, Integration, Shared Services) | How Does it Align to ZSP Priorities? Which Ones? | Service Responsibility Addressed |
|---|---|---|---|---|---|---|
| MSE | Physician Engagement Program | **Goal:**<br>• To ensure member involvement in improving current and shaping future programs and to ensure high levels of engagement across the membership.<br>**How:**<br>• The Physician Engagement Program includes several components that support communication between members and the network in support of improved physician engagement, input, and feedback into program planning, development, and improvement. | • Strong Partnerships and Transitions of Care<br>• Health Needs of the Community and Population | • Alignment<br>• Integration | Patient Medical Home | • Chronic screening/ prevention<br>• Population Health<br>• Information Management<br>• Complex Care |

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| | | • Physician Liaisons: Continued use of the Physician Liaison role as main point of contact for members to obtain information, provide feedback, ask questions, and request support for resolution of practice or staff-related issues.<br>• Feedback monitoring and tracking to identify themes or trends.<br>• Development of an annual "engagement report" to share with membership the feedback themes from all three priority areas and report on any actions/improvements made based on feedback.<br>• Development and implementation of a PMH Community of Practice to encourage and support members in building their PMH through QI activities.<br>• Continued engagement opportunities for physicians to provide input into program planning, development, and improvement:<br>  • Focus groups (members are remunerated for their time)<br>  • One-on-one interviews (members are remunerated for their time)<br>  • Surveys and polls<br>• Physicians will continue to be remunerated for time spent in certain engagement opportunities listed above.<br>• Development of networking events or activities to enhance connections between members and across the PCN.<br>• Enhance experience and uptake of digital engagement platform.<br>• Development of a physician awards program.<br>**Program staff include:**<br>• 1.0 FTE Physician Liaison Lead<br>• 2.6 FTE Physician Liaisons<br>• 1.0 FTE Member Services Coordinator<br>• 1.0 FTE Member Services & Engagement Administrative Assistant<br>• 2.0 FTE Community Integration Consultants | • Patient Medical Home | | | |

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| | | **What this will achieve:**<br>• Engaged members will be more open about how we can best support them and their patients, providing constructive feedback on our programs and services. This will allow the CWC PCN to further meet the needs of its members and their patients, improving the effectiveness of resources.<br>• Engaged members will support the CWC PCN's primary objective, working with us in our journey to build Patient Medical Homes and medical neighbourhood. Engaged members will be better aware of network programs and motivated to utilize them. Physicians who use PCN programs and services to meet the needs of their patients will have higher job satisfaction and work-life balance. | | | | |
| MSE | Membership Model Management Program | **Goal:**<br>• To effectively manage the lifecycle of physician membership, ensuring positive member experiences.<br>**How:**<br>• Oversight of the membership model requires ongoing support to effectively onboard and offboard members and ensure their alignment with the appropriate membership type.<br>• Several key functions are supported through this program:<br>  • Managing membership applications<br>  • Onboarding new members and offboarding members who have end-dated<br>  • Conducting annual membership reviews to ensure members are complying with the expectations of their membership type.<br>  • Annual updates to the *Physician Accountability Agreement*<br>  • Further refinement of our membership model, developing guidelines around programs and services in support of pediatricians and nurse practitioners and other groups as needed<br>  • Continued improvements to the membership application and orientation process | • Accountable and Effective Governance<br>• Strong Partnerships and Transitions of Care<br>• Health Needs of the Community and Population<br>• Patient Medical Home | • Alignment<br>• Integration | Governance | • Information Management |

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| | | • As outlined in the previous business plan, PMH Activity-Based Payments were phased out over the plan's three-year period.<br>• That decision was influenced by Alberta Health policies regarding physician payments, and funds were reinvested into direct patient care services (e.g., more nursing and mental health staff).<br>**Program staff include:**<br>• 1.0 FTE Physician Liaison Lead<br>• 2.6 FTE Physician Liaisons<br>• 1.0 FTE Member Services Coordinator<br>• 1.0 FTE Member Services & Engagement Administrative Assistant<br>**What this will achieve:**<br>• Efficient processing of membership applications<br>• Positive member experiences leading to good word of mouth for further physician recruitment<br>• Accountability of PCN and member expectations | | | | |
| MSE | Practice Support Program | **Goal:**<br>• To provide members with resources and services to help with their everyday practice and support compliance with regulatory bodies.<br>**How:**<br>• Supports available through this program include:<br>  • Assessing and supporting member clinics to comply with Occupational Health and Safety legislation<br>  • Online clinical practice tools including UpToDate and Lexicomp<br>  • Providing members with translation services through LanguageLine Solutions.<br>  • Providing tools and resources to ensure privacy compliance<br>  • Development and implementation of a Community of Practice for practice owners to better understand their operational needs and support knowledge sharing | • Accountable and Effective Governance<br>• Strong Partnerships and Transitions of Care<br>• Health Needs of the Community and Population<br>• Patient Medical Home | • Alignment<br>• Integration | Governance | • Complex care<br>• Population health<br>• Chronic screening/ prevention<br>• Information Management |

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| | | • Development of a clinic operations support offering to physician offices, including but not limited to, the following clinic operation functions:<br>  • Information technology<br>  • Human resources<br>  • Occupational health and safety<br>  • Recruitment and staffing<br>  • Equipment and supplies<br>  • Privacy and security<br>• Development and implementation of a service to connect member clinics with nearby community pharmacies (and other service providers such as physiotherapists and dietitians) to:<br>  • Strengthen relationships between medical home and medical neighbourhood (enhanced continuity of care)<br>  • Capitalize on the services provided by community resources that will support patient care<br>**Program staff include:**<br>• 1.0 FTE Physician Liaison Lead<br>• 2.6 FTE Physician Liaisons<br>• 1.0 FTE Member Services Coordinator<br>• 1.0 FTE Member Services & Engagement Administrative Assistant<br>**What this will achieve:**<br>• Providing practice-related supports to members allows them to spend less time worrying about their day-to-day operations and more time on patient care.<br>• Connecting members with community resources to support their practice and patients' needs. | | | | |
| MSE | Physician Continuing Medical Education and Professional Development Program | **Goal:**<br>• To provide members with learning opportunities in alignment with PCN objectives.<br>**How:**<br>• The Continuing Medical Education and Professional Development (CME & PD) Program supports learning and information exchange opportunities that align with the provincial PCN objectives. | • Strong Partnerships and Transitions of Care<br>• Health Needs of the Community | • Alignment<br>• Integration | Governance | • Information Management |

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| | | • Chairing the Calgary Zone PCN CME Collaborative to align and maximize value of offerings across Calgary PCNs and to align priorities.<br>• Partnering with the U of C's Department of Family Medicine to leverage their CME offering and expertise.<br>• Collaborating with the Calgary Zone PCNs, U of C, and the ACFP to develop a harmonized approach to gathering information about physicians' CME interests and needs.<br>• Representing the PCNs and participating in the CPD Provincial Network steering committee and/or working groups. Customized content will be developed as well as existing content sourced out.<br>• Educational opportunities will align with the CWC PCN's CME & PD Framework, which specifies the following streams:<br>  • Practice Support, including Physician Wellness<br>  • Patient Medical Home<br>  • Community Services, Transitions, and Integration<br>  • Primary Care Partners<br>**Program staff include:**<br>• 1.0 FTE MSE Administrative Assistant<br>• 1.0 FTE Events Planner<br>• 1.0 FTE Communications Advisor<br>• 1.0 FTE Marketing Specialist<br>• 1.0 FTE Communications Coordinator<br>**What this will achieve:**<br>• Building physicians' skillset and knowledge to further enhance the patient care they provide<br>• Less duplication of efforts across the zone and more maximization of resources | and Population<br>• Patient Medical Home | | | |

| Description of Risk | Zone PCN Service Plan Priority Initiative | Activities to Mitigate/Prevent the Risk from Occurring | Strategies to Address the Risk Should it Occur |
|---|---|---|---|
| Attracting and retaining skilled employees to meet the needs of the program | • To establish robust governance, planning and operational structures | • Offer innovative and interesting work<br>• Competitive salaries and benefits packages | • Innovative recruitment strategies |
| Members leaving PCN due to retirement or moving may result in decrease in funding. | • To establish robust governance, planning and operational structures<br>• To harmonize implementation of the PMH by standardization of tools and resources across the zone | • Continued recruitment of members and outreach to universities to encourage new grads to join CWC PCN<br>• Offer transition support to ensure patients of retiring physicians get connected to CWC PCN members<br>• Regular review of budget | • Monitor and adjust budget to meet any changes in per-capita funding<br>• Expand outreach to non-member physicians to show value of PCNs |
| Physicians' limited mental bandwidth can make it difficult to get key messages/information across. | • To improve the continuous, personal relations to the PMH by supporting strong transitions of care across the health system<br>• To harmonize implementation of the PMH by standardization of tools and resources across the zone | • Use new engaging strategies/tactics with a marketing lens | • Multi-channel communications<br>• Assess and analyze modes of communication to determine most optimal approaches |

## 2.4.1. Implementation Timeline

| Time Period | Key Activities | Deadlines, Goals and Comments |
|---|---|---|
| April 2022 – March 2023 | Develop community of practice of practice owners.<br>Conduct needs assessment for clinical operations support. | Developing a dedicated community practice for practice owners will facilitate improved understanding of CWC PCN initiatives and streamline communications when new programs and services are introduced to physician members. |
| April 2023 – March 2025 | Implementation of clinical operations support. | With physician members facing increased administrative pressures as their practices evolve post-COVID-19, the CWC PCN wishes to explore different avenues where supports can be provided. Analysis of members' needs will determine what services and supports are developed and offered. Consultation will occur in 2022-23 with planning and implementation to follow in 2023-24. |
| April 2023 – March 2024 | Harmonize CME & PD needs assessment activities for U of C, ACFP, and PCNs. | Ongoing professional development and learning are crucial to physician members' capacity to deliver high quality care in a constantly evolving primary care environment. The CWC PCN's physician members are no different from their peers in other Calgary Zone PCNs, so efforts will be made to harmonize, share, and streamline CME & PD offerings across the Calgary Zone, and whenever possible, province. |
| April 2022 – April 2023 | Develop clinic engagement program offerings for clinic managers and staff. | Clinic managers and staff play a pivotal role in the successful implementation of all CWC PCN programs and services. Dedicating time and effort to building stronger relationships with these individuals and understanding their needs and expectations will facilitate improvement in this domain. |

# 2.5. Priority Initiatives: Governance and Central Allocations

**Risks and Mitigating Activities Associated with Governance and Central Allocations.**
**Priority Initiatives including the programming your PCN offers in support of a Zone Service Plan Priority Initiative.**

Governance influences how an organization's objectives are set and achieved, risks are monitored and addressed, and performance is optimized. Rather than a single activity, governance is a system of processes. As such, the successful implementation of a good governance strategy at both the Board (strategic) and organizational (operational) level requires a systematic approach that incorporates strategic planning and risk and performance management. The CWC PCN's Board of Directors provides the framework for strategic planning, effective implementation, and monitoring of the organization's progress. The Board practices good governance by supporting management and employees to be the best they can be, thus ensuring that the organization is well positioned to adapt to the changing external environment. This section of the business plan articulates how the Board will continue to govern and optimize its collective skillset in accordance with direction from Alberta Health (AH), and how the Executive Director will lead the organization to ensure goals are pursued ethically, prudently, and efficiently in alignment with the Board Ends Policies and AH Primary Care Initiative policies, priorities, and strategic objectives.

Optimal organizational functioning can be achieved when good governance principles and practices are implemented and evaluated at all levels of an organization. At the CWC PCN, central allocations translates the strategic direction set by the Board to the day-to-day structure and priorities of the organization. Central allocations encompass governance, policy, privacy, information technology, facilities management, project management, fund development, finance, communications, and human resources. Collectively, these teams ensure the effective, efficient, and ethical use of CWC PCN's human and financial resources for its members, patients and families, employees, and stakeholders.

| **Priority** | **Element** | **Service Scope Description** | **How it Aligns to PCN Objectives** | **How it Aligns to ZSP Objectives** (Alignment, Integration, Shared Services) | **How Does it Align to ZSP Priorities? Which Ones?** | **Service Responsibility Addressed** |
|---|---|---|---|---|---|---|
| Governance and Central Allocations | Board Governance Program | **Goal:**<br>• The CWC PCN will expand on and implement Board policies, processes, training, and development practices.<br>**How:**<br>• The CWC PCN will demonstrate its commitment to effective and accountable Board governance by:<br>• The CWC PCN achieved Accreditation excellence through Accreditation Canada including more than 80 governance standards. The organization and Board are committed to remaining in compliance with Accreditation Canada's governance standards and exceeding them through ongoing assessment: | Accountable and Effective Governance | Alignment | Governance | Information Management |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | • Developing a digital library of Board governance and training materials following Accreditation Canada standards, internal policies and procedures, and current best practices<br>• Develop and enhance CWC PCN-specific resource documents, virtual training, and onboarding for Board members<br>• Regularly reviewing Accreditation Canada's governance standards to ensure that Board and governance practices are always improving<br>**Program staff include:**<br>• 1.0 FTE Governance and Policy Lead<br>• 1.0 FTE Board Governance Coordinator<br>**What this will achieve:**<br>• Upholding a governance framework that adheres to the highest of national governance standards, and supported by exceptional onboarding and training, will allow the Board to govern effectively, understand and mitigate risk, and make prudent decisions that support the organization's strategic objectives and the Primary Care Objectives established by AH. | | | | |
| Governance and Central Allocations | Human and Financial Resource Planning and Deployment Program | **Goal:**<br>• The CWC PCN's Human Resources and Finance teams manage the CWC PCN's human and financial resources. They implement programs to help the organization work collaboratively and maximize efficiency, productivity, and effectiveness to serve all stakeholders. Additionally, the CWC PCN Finance team will provide the Calgary Zone with financial services and supports.<br>**How:**<br>• The organization will implement the following human resource and financial strategic goals:<br>• Expand upon the recently implemented cloud-based accounting system, focusing on value-added integrations and reducing data entry<br>• Leverage integrated cloud accounting tools to enhance analysis and forecasting | Accountable and Effective Governance | Alignment | Governance | Information Management |

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|---|---|---|---|---|---|---|
| | | • Reduce redundancies by improving financial tracking and the timeliness of reports<br>• Collaborating with HR and Information Technology to better support employees by exploring a support ticket system for Finance and HR<br>• Formally completing a total compensation market survey and job evaluation review in 2024, aiming to ensure the CWC PCN remains competitive to recruit and retain talent<br>• Offering professional development opportunities for management and staff<br>• Educating employees on and our occupational health and safety management system in accordance with Accreditation Canada's standards of excellence<br>• Use data-informed decision-making within the new HR information management system to create efficiency and effectiveness across HR programs<br>**Program staff include:**<br>• 5.0 FTE finance staff including a senior accountant, payroll, analysts, and contracts specialist<br>• 4.0 FTE human resources staff including HR generalists, administrative support, and a recruiter<br>**What this will achieve:**<br>• The Human and Financial Resource Planning and Deployment Program will support organizational excellence by helping ensure the organization has the appropriate human and financial capital so that physician members and allied healthcare teams can address their patient needs and exceed their professional standards. | | | | |
| Governance and Central Allocations | Policy and Risk Analysis Program | **Goal:**<br>• The organization will continue to ensure that both Board and administrative policies align with provincial regulations, privacy legislation, evidence-based best practices, and Accreditation standards. | Accountable and Effective Governance | Alignment | Patient Medical Home | Information Management |

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|---|---|---|---|---|---|---|
| | | **How:**<br>• Additional policy development work includes:<br>  • Virtual care services policies addressing the specific functions and responsibilities of the organization's colocated and remote employees<br>  • Allied health professional policies outlining the integration of the professional networks that represent some CWC PCN employees, including Registered Nurses, Licensed Practical Nurses, Social Workers, and Registered Psychologists<br>  • Expanding patient safety policies with strategic plans and guidelines to prevent patient abuse and/or incidents<br>  • Developing policies and guidelines on strategic grant acquisition and fund development<br>• Following the organization's *Risk Management Framework Policy and Business Continuity Plan*, the CWC PCN seeks to take a more intentional and proactive approach to risk analysis by developing risk registers for all teams and departments to regularly review.<br>• Through ongoing risk analysis, the CWC PCN will be able to develop standard operating procedures and other necessary documentation to ensure that all risks have been properly documented and mitigated.<br>**Program staff include:**<br>• 1.0 Governance and Policy Lead<br>• 1.0 Policy and Procedures Coordinator<br>**What this will achieve:**<br>• The CWC PCN will continue to ensure ethical behaviour from bedside to boardroom is a key priority to ensure that questions and decisions are deliberated and discussed based on sound policies, procedures, ethical considerations, and risk analysis. | | | | |

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|---|---|---|---|---|---|---|
| Governance and Central Allocations | Privacy and Information Technology Program | **Goal:**<br>• Privacy and Information Technology (IT) work together to ensure secure access to facilities, assets, and data. This includes managing the health information of CWC PCN healthcare providers, employees, and patients.<br>• The CWC PCN's privacy goals help ensure information is managed following guidance from the Officer of Information and Privacy Commissioner of Alberta. The Privacy Governance Advisor handles privacy incidents, manages requests for access to information, ensures continued compliance with records retention requirements, and provides privacy education and training to employees and physician members.<br>• The CWC PCN contracts a third-party vendor to provide day-to-day IT ticketing support and support the organization's server hosting. The CWC PCN also employs IT Business Analysts who provide support, manage all IT business applications, and advance the organization's strategic IT projects and goals.<br>**How:**<br>*Transforming care*<br>• Improve and expand safe and secure care options by offering an expansive collaborative virtual care platform and patient-triggered bookings<br>• Create a new data governance strategy to build on the organizations track record of success when managing data to support the organization's approach to evidence-informed decision-making<br>*Value and sustainability*<br>• Migrate on-premises systems to cloud platforms to efficiently deploy and scale a more mobile IT infrastructure, reduce maintenance costs, and transition to paperless operations<br>*Strengthen the infrastructure*<br>• Improve overall information management by migrating to SharePoint in Microsoft 365 and implementing a faster and more secure VPN | • Accountable and Effective Governance<br>• Patient Medical Home | Alignment | Patient Medical Home | Information Management |

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|---|---|---|---|---|---|---|
| | | • Enhanced digital training program that will test and reinforce privacy and security practices for Board members, employees, and physician members<br>**Program staff include:**<br>• 1.0 FTE Privacy Governance Advisor<br>• 2.0 FTE IT Business Analysts<br>**What this will achieve:**<br>• These initiatives will allow the organization to:<br>  • Reduce annual IT costs<br>  • Transmit information more securely and reliably<br>  • Better protect patient and institutional data<br>  • Use digital resources more efficiently | | | | |
| Governance and Central Allocations | Facilities and Operations Program | **Goal:**<br>• The CWC PCN has seen measurable benefits since transitioning to a virtual/hybrid environment, including cost savings, increased productivity across all teams, and improved occupational health and safety. By continuing to offer this hybrid work model, the CWC PCN can explore opportunities to significantly reduce overhead administrative Main Office costs that would otherwise be allocated to a traditional office setting.<br>• The organization's engagement processes also help raise awareness of the PCN's programs and services, policies, and standard operating procedures. Through this process, the perspective of stakeholders is incorporated into strategic and quality improvement initiatives, knowledge of community partners and programs are shared, and employees are connected to the PCN's mission, vision, and values.<br>**How:**<br>• The CWC PCN will look to transfer its current lease and move to a smaller Main Office space that supports the organization's permanent hybrid/virtual working model. The organization will reinvest cost savings from the lower lease costs directly into patient care and into supporting workforce operations. | • Accountable and Effective Governance<br>• Patient Medical Home | Alignment | Patient Medical Home | Information Management |

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|---|---|---|---|---|---|---|
| | | • The CWC PCN will continue to engage with its employees, patients, and physician members to ensure stakeholder needs are supported within the organization's hybrid work model.<br>**Program staff include:**<br>• 6.0 FTE of communications staff including written, visual, and digital communications, social media, web development, marketing, and coordination.<br>• 1.0 FTE for Facilities and IT Administration.<br>**What this will achieve:**<br>• These initiatives will allow the organization to achieve the following:<br>  • Continued engagement between the organization and its stakeholder<br>  • Significant cost savings that will be reinvested into patient care and workforce operations<br>  • Increased workforce efficiency<br>  • Protecting employees, providers, patients against COVID-19 | | | | |
| Governance and Central Allocations | Management of Programs | • Management staff will oversee the strategic direction and program delivery of the Governance and Central Allocations program include the following:<br>  • 1.0 FTE Manager, Governance & Organizational Operations (Governance, Policy, Privacy, IT, Facilities Management, Fund Development)<br>  • 1.0 FTE Manager, Finance<br>  • 1.0 FTE Manager, Human Resources | Accountable and Effective Governance | Alignment | Patient Medical Home | Information Management |

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|---|---|---|---|---|---|---|
| Zonal Governance | Other Calgary Zone Activities (Shared Services) | • There are several activities and functions that are happening within specific PCNs, the Calgary Zone, and provincial PCNs. These allow us to leverage off one another, share costs/explore economies of scale, and avoid redundant services and costs. The following shows how the CWC PCN and the Calgary Zone benefit by this relationship.<br>**CWC PCN:**<br>• The CWC PCN benefits from being part of the various communities of practice sharing knowledge and best practices (governance, HR, privacy, finance, communications, PMH, community services).<br>• CWC PCN Privacy Governance Advisor serving as Co-Chair of PCN Provincial Privacy Community of Practice shares their expertise and acquires greater knowledge and provincial updates related to privacy.<br>• The CWC PCN is working with other PCNs on joint purchasing power opportunities to lower procurement costs for supplies and vendor contracts.<br>**Calgary Zone**<br>• Communications (including promotions, surveys, media training, weekly social media post, etc.)<br>• Continuing Medical Education and Professional Development opportunities<br>• Regular meeting with Executive Directors to support one another and explore opportunities to align operations<br>• Regular meetings with Medical Directors to address clinical decision support gaps and develop clinical standards | Accountable and Effective Governance | Alignment | Governance | Information Management |

| Description of Risk | Zone PCN Service Plan Priority Initiative | Activities to Mitigate/Prevent the Risk from Occurring | Strategies to Address the Risk Should it Occur |
|---|---|---|---|
| Adequate funding to meet patient needs | • To establish robust governance, planning and operational structures | • Work closely with AH to ensure all organizational programs and services align with AH PCN objectives to ensure there are no delays in AH funding<br>• Develop a fund diversification strategy to increase funding to the CWC PCN through grants, donations, and social enterprise<br>• Continue to provide management and Board with accurate and up-to-date financial reporting to ensure the organization understands its current and forecasted financial positions | • Maintain open communication and a strong working relationship with AH<br>• Evaluate all current spending and determine where costs can be trimmed<br>• Continue to work on obtaining grants and securing funds outside of regular AH per-capita funding |
| Recruiting and retaining quality Board members who understand the role of PCNs, and the objectives set forth by Alberta Health | • To establish robust governance, planning and operational structures | • Recruit physician members who are engaged, believe in the PMH model, and would be interested in becoming a leader on the Board<br>• Offer physician members interested in Board work the opportunity to engage with a Board sub-committee as a member at large, pending Board approval<br>• Continue to improve the annual new Board member orientation and training series<br>• Continue to improve Board policies and resource materials for the Board to better understand their roles and responsibilities<br>• Continue to work with Accreditation Canada and ensure the Board is adhering to the highest of national governance standards | • Evaluate onboarding and training for new Board members<br>• Develop communications and engagement plans with members to recruit qualified individuals<br>• Work closely with AHS Joint Venture Governance Committee partners to maintain Board continuity while we recruit new members<br>• Continue to seek out qualified members of the public to serve on the Board |
| Attracting and retaining quality resources to meet the needs of the organization | • To establish robust governance, planning and operational structures | • Offer innovative, intrinsically motivating, and interesting work<br>• Competitive salary and benefits packages, flexibility, and engagement opportunities | • Strengthen recruitment and employee engagement opportunities<br>• Create a culture where employees are invested in their work<br>• Look at innovative ways to increase retention, such as working from home opportunities |

| | | | |
|---|---|---|---|
| Privacy and security of information | • To establish robust governance, planning and operational structures<br>• To harmonize implementation of the PMH by standardization of tools and resources across the zone | • Restrict access and management of data to a limited set of people who have a business need for it<br>• Staff handling identifiable patient data will undergo additional training to ensure they understand the risks and their responsibilities to protect the information<br>• Secure encryption of all data and information housed by the CWC PCN<br>• Mandatory annual employee privacy training tailored to meet all specific roles in the organization<br>• Restrict the use of third-party service providers to those who can adequately maintain the security and privacy of CWC PCN's information | • Instances of non-compliance with privacy policies and procedures are documented and reported in a virtual case management software. Learning or disciplinary measures are implemented immediately.<br>• Notification is given immediately in writing to the Office of the Information and Privacy Commissioner<br>• Notification is given immediately in writing to the affected individuals |
| Maintaining business continuity | • To establish robust governance, planning and operational structures | • Regularly review corporate and departmental business continuity plans and *Crisis Communications Framework*<br>• Utilize and regularly back up server data | • Implement business continuity plan and *Crisis Communication Framework*<br>• Conduct post-event review of continuity plans, update accordingly, and provide internal training |
| Managing compliance, fraud, and liability risks | • To establish robust governance, planning and operational structures | • Maintain adequate finance records in alignment with administrative policies to efficiently and accurately report on compliance (e.g., AHS, CRA)<br>• Practice professional skepticism and limit access to financial systems and data to only individuals who require it<br>• Regularly review the coverage, quality, and cost of the existing insurance plan to safeguard against potential liability risks (i.e., content, cyber, liability) | • Review internal financial controls, policies, and standard operating procedures<br>• Conduct review or audit of insurance coverages |

## 2.5.1. Implementation Timeline

| Time Period | Key Activities | Deadlines, Goals and Comments |
|---|---|---|
| October 2022 – October 2024 | Preparation for Accreditation Canada onsite survey in October 2024. | Understand, identify, and implement the new Accreditation Canada standards around governance, leadership, and clinical primary care standards.<br>Work to ensure we are continuing to meet the standards from the 2020 survey.<br>Develop plans to ensure we achieve the standards from the 2022 survey that were unmet ahead of 2024. |
| April 2022 – March 2023 | Migration from on-premises network drives to SharePoint in Microsoft Office 365.<br>Migration to enterprise mobility management cloud-based systems. | Segmented project phases to migrate individual departments over to SharePoint, along with applying record retentions to old data.<br>Building metadata criteria for ease of use and retrievability.<br>Ensuring end-to-end encryption systems are in place to protect all data.<br>Developing a change management plan including employee training and stakeholder engagement sessions. |
| April 2022 – March 2023 | Developing a framework for all administrative working groups to maximize value for time invested and ensure successful outcomes. | Develop new physician and employee advisory groups in addition to Patient Advisory Council.<br>Develop new patient safety strategy for recognizing and preventing patient abuse with the support of the Patient Safety Committee. |
| April 2022 – December 2022 | Grant Acquisition Strategy developed. | Develop grant funding strategies for all clinical areas to help identify grants that align with AH PCN objectives and that the CWC PCN would be eligible for to support and enhance the work of clinical teams.<br>Develop fund acquisition policies and guidelines.<br>Test assumptions and evaluated grant seeking effectiveness to determine if the grant strategy needs to be adjusted. |
| January 2024 – December 2024 | Conduct review of all roles to ensure total compensation is in alignment with the market as compared to other similar health, non-profit, and community agencies | Obtain data analysis on pay levels to access market competitiveness by market, region, and industry.<br>Analysis against the market using the CWC PCN's pay philosophy and guidelines to provide an understanding of competitive market practices and insight into other market pay-mix policies.<br>Obtain data analysis of CWC PCN data to gauge internal parity and ensure alignment of actual pay practices to pay policy. |
| March 2022 – September 2023 | *Virtual Care Policy* launch<br>*Allied Roles Health Policy* launch | Launch virtual care policies in the winter/spring of 2022. Between the spring and summer of 2022, standard operating procedures and user manuals will be developed for virtual care policies to enforce key practices.<br>Develop role-specific policies and procedures for all allied health roles, supplementing what each professional college dictates and to provide guidance and direction on how care is managed at the CWC PCN. |

# 3. Information Management

| IM Current State | IM Desired State | IM Budget | Existing Strategies | Planned Strategies | IM and Technology Plans |
|---|---|---|---|---|---|
| TELUS Health WOLF EMR for the Primary Care Centre | TELUS Health WOLF EMR with the ability to extract from WOLF to Snowflake to evaluate outcomes more closely. | $75,000 | • Research and information gathering for suitable EMR system.<br>• All patient records are stored within WOLF at CWC PCN. | Create a data governance strategy that will include the secure migration of the patient's health information from one system to another. | Implement an appropriate EMR for the CWC PCN's Primary Care Centre. |
| Virtual Healthcare delivery: POMELO for PCRNs and PCRPs. | • POMELO<br>• Med Access | $25,000 | POMELO provides a secure connection to the patient with limited functionalities and allows for integration with TELUS EMRs. | Develop internal policies and operating procedures to govern the delivery of virtual healthcare. | Implement a virtual healthcare system to improve physician and patient experience using platforms such as POMELO. |
| Analyzing EMR data from physician member PMH clinics using Snowflake and Tableau. | Continue this process and develop refinements as needed. | $26,000 | • Analyze panel patient data for insights to improve service delivery.<br>• Data is extracted by HICs and uploaded into Snowflake. From Snowflake, the data is analyzed in Tableau for reporting. | Continue to support program service delivery. | Ensure continued compliance with data privacy legislation. |
| Analyzing EMR data by PCRPs | Continue this process and develop refinements as needed. | See the rows above. | Patient data is stored within the CWC PCN's Med Access EMR. Data is extracted internally within the CWC PCN and uploaded to Snowflake. From Snowflake, the data is analyzed in Tableau for reporting, evaluation, and quality improvement. | Continue to support program service delivery. | Ensure continued compliance with data privacy legislation. |

| | | | | | |
|---|---|---|---|---|---|
| Support eligible physician members implementing CII/CPAR. | Full participation in CII/CPAR. | NA. Staffing costs only. No additional technology or information management costs. | A collaborative effort between the physician, Physician Liaison, PCN Privacy Governance Advisor, and external privacy consultant to ensure that physician members with identified panel have access to support when filing CII/CPAR-related Privacy Impact Assessment (PIA) updates. | Continue to track engagement and develop processes and incentives for members to participate. | Physicians participating in CII/CPAR receive a discrepancy report from AH. The PCN's HIC supporting the physician member will securely access the report and clear up any existing discrepancies. |
| Privacy and Security:<br>• In compliance with Alberta's *Health Information Act* section 64, the CWC PCN submits a PIA to identify and mitigate privacy risks associated with the collection, use, and disclosure of health information.<br>• The CWC PCN's recent submission (OIPC File# 015853, accepted May 28, 2021) identifies the privacy and security requirements for the PCN's most recent initiatives along with an update to our organizational management. | New PIA will be submitted to the OIPC in 2022 including all updates to technology and processes related to how proposed administrative practices or information systems may affect the privacy of the individuals who are the subjects of the information. | NA | The CWC PCN will review all PIAs for compliance on an annual basis. | NA | NA |

# 4. Financial Plan

## 4.1. PCN Budget Summary

### 4.1.1. Table 4.1A: Financial Plan Summary

| Financial Plan Summary[@] in thousands of dollars with one decimal place | | | | |
|---|---|---|---|---|
| **Revenue Sources** | **April 1, 2022, to March 31, 2023** | **April 1, 2023, to March 31, 2024** | **April 1, 2024, to March 31, 2025** | **Full Term** |
| Per Capita Funding[@@] | $18,937.7 | $18,786.0 | $18,755.0 | 56,478.7 |
| Interest and Investment Income | 15 | 15 | 15 | 45.0 |
| Other (specify) | | | | 0.0 |
| Nurse Practitioner Funding | 350 | 350 | 350 | 1,050.0 |
| ① **Revenue Totals** | **$19,302.7** | **$19,151.0** | **$19,120.0** | **$57,573.7** |
| Patient Medical Home | 7,525.0 | 7,525.0 | 7,525.0 | 22,575.0 |
| Community Services | 3,692.0 | 3,592.0 | 3,592.0 | 10,876.0 |
| Member Services & Engagement | 1,418.0 | 1,403.0 | 1,408.0 | 4,229.0 |
| Central Allocations | 5,902.7 | 5,856.0 | 5,820.0 | 17,578.7 |
| Zonal Allocations | 365.0 | 375.0 | 375.0 | 1,115.0 |
| Nurse Practitioner Allocations | 350.0 | 350.0 | 350.0 | 1,050.0 |
| ② **Expense Subtotal[@]** | **$19,252.7** | **$19,101.0** | **$19,070.0** | **$57,423.7** |
| | | | | |
| **Subtotal ①-② [@] [@@@]** | **$50.0** | **$50.0** | **$50.0** | **$150.0** |
| ③ **Budgeted Yearly capital asset purchase(s) >$2.5K*** ** | **$50.0** | **$50.0** | **$50.0** | **$150.0** |
| **Total Cash outlay ②+③** | **$19,302.7** | **$19,151.0** | **$19,120.0** | **$57,573.7** |
| **Balance ①-②-③** | **$0.0** | **$0.0** | **$0.0** | **$0.0** |

## 4.1.2. Table 4.1A.1: Budgeted Capital Asset Purchases and Amortization

| **Summary of all budgeted capital asset purchases and amortization*** in thousands of dollars with one decimal place | | | | |
|---|---|---|---|---|
| For capital assets >$2,500 | **April 1, 2022, to March 31, 2023** | **April 1, 2023, to March 31, 2024** | **April 1, 2024, to March 31, 2025** | **Three-year total** |
| 1. Capital asset purchases** *** during year | 50.0 | 50.0 | 50.0 | **150.0** |
| 2. Yearly amortization expense | 125.0 | 125.0 | 125.0 | **375.0** |

## 4.1.3. Table 4.1B: Expense Estimate by Priority Initiative and Payment Type

**Calgary West Central Primary Care Network**

### Expense Estimate by Priority Initiative and Payment Type

| Priority Initiatives | | Payments to Physicians three-year total | | Payment to AHS three-year total | | Non-Phys. Direct Care Providers three-year total | | Other Expenses three-year total | | % | Three-Year Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Medical Home** | C: | 0.0 | | 0.0 | Registered Nurses | 9,900.0 | Clinical Support Staff | 6,990.0 | | 16,890.0 |
| | A: | 60.0 | | 0.0 | Registered Psychologists | 5,490.0 | Other | 135.0 | | 5,685.0 |
| | O: | 0.0 | | 0.0 | | 0.0 | | 0.0 | | 0.0 |
| **Patient Medical Home Totals** | | **60.0** | | 0.0 | | 15,390.0 | | 7,125.0 | | 22,575.0 |
| **Community Services** | | | | | | | | | | |
| | C: | 2,800.0 | | 0.0 | RN & LPN | 1,185.0 | Clinical Support Staff | 3,285.0 | | 7,270.0 |
| | A: | 15.0 | | 0.0 | Pharmacist | 345.0 | Health Equity Support | 1,875.0 | | 2,235.0 |
| | O: | 0.0 | | **0.0** | Social Worker | **1,665.0** | Other & FFS Revenue | **(294.0)** | | **1,371.0** |
| **Community Services Totals** | | 2,815.0 | | 0.0 | | 3,195.0 | | 4,866.0 | | 10,876.0 |
| **Member Services & Engagement** | | | | | | | | | | |
| | C: | 0.0 | | 0.0 | | 0.0 | Clinical Support Staff | 2,160.0 | | 2,160.0 |
| | A: | 360.0 | | 0.0 | | 0.0 | Physician Resources | 900.0 | | 1,260.0 |
| | O: | 420.0 | | **0.0** | | **0.0** | Other | **389.0** | | **809.0** |
| **Member Services & Engagement Totals** | | 780.0 | | 0.0 | | 0.0 | | 3,449.0 | | 4,229.0 |
| **Priority Initiative Allocations** | 10% | **3,655.0** | **0%** | **$0.0** | **49%** | **$18,585.0** | **41%** | **$15,440.0** | **68%** | **$37,680.0** |
| **Allocations not specific to a particular initiative** | Medical Director | 315.0 | | 0.0 | | 0.0 | Evaluation Resources | 130.0 | | **445.0** |
| | PCN (JV Gov'nce) | 0.0 | | 0.0 | | 0.0 | PCN Admin Lead | 561.0 | | **561.0** |
| | NPC | 720.0 | | 0.0 | | 0.0 | Other Mgt | 0.0 | | **720.0** |
| | Forum, etc | 0.0 | | 0.0 | | 0.0 | Administration | 6,975.0 | | **6,975.0** |
| | | 0.0 | | 0.0 | | 0.0 | Info Technology | 1,800.0 | | **1,800.0** |
| | | 0.0 | | 0.0 | | 0.0 | Support Services | 2,865.0 | | **2,865.0** |
| | | 0.0 | | 0.0 | | 0.0 | Other | 4,212.7 | | **4,212.7** |
| **Central Allocations Subtotal** | | **1,035.0** | | **0.0** | | **0.0** | | **16,543.7** | **32%** | **$17,578.7** |
| | | | | | | | | | | |
| **Budget Estimate Totals by Category** | 8% | **4,690.0** | 0% | **0.0** | 34% | **18,585.0** | 58% | **31,983.7** | 100% | **55,258.7** |

| | 3 year total | | |
|---|---|---|---|
| **Memo: Breakdown of Payments to Physicians** | 77% | $2,800.0 | **Clinical** (direct patient care + interaction with team members that is related to specific patients/families, availability, minimum shift guarantees) |
| | 12% | $435.0 | **Administrative** (governance and mgt for PCN/NPC, initiative mgt, program development, etc.) |
| | 11% | $420.0 | **Other** (education/training, cost recovery, etc.) |
| **Total** | **100%** | **$3,655.0** | This total must match the total Payments to Physicians above. |

# 5. Evaluation of the PCN

The CWC PCN uses a *Quality and Safety Framework* and a *Performance Measurement Framework* to generate information for strategic decision-making, monitoring, and evaluation. As these frameworks becomes fully implemented, they will increase the ability of the CWC PCN to monitor the impact of programs and services on patient care. Regular reporting on the effectiveness of our PMH services is a central goal of our evaluation activities. To effectively and efficiently monitor and report on key measures, a major objective is to create standard consistent data capture and reporting mechanisms that support quality improvement strategies for improving patient outcomes within the PMH. To support and implement this work, the CWC PCN has dedicated two positions: a Research & Evaluation Consultant (1.0 FTE) and a Measurement Analyst (1.0 FTE) who are responsible for evaluation implementation, analytics, and reporting (including operational reporting). A project coordinator (1.0 FTE) assists the PMH team with project evaluation support and team administrative tasks. In addition, to support the management, analysis, and reporting of patient care improvement data, three positions, including a Lead Measurement Consultant (1.0 FTE), and Data Warehouse Developer and Support Analysts (2.0 FTE), work closely with PMH teams to support quality improvement reporting and work with operations to provide business planning reports. These roles are supervised and report to the Director of PMH.

The evaluation and measurement team use a collaborative approach with leadership, staff, and physician members, as appropriate, to develop the strategic evaluation and performance measurement. In addition, the CWC PCN will continue to collaborate with partners, such as, AHS, the HQCA, and other provincial and regional programs as needed to develop robust and beneficial approaches to evaluation and program delivery.

| Priority Initiative | Element | Evaluation Approach | Roles that Support this Approach | Measurement / Metric (Key Indicator) | Alignment to Schedule B | Method for Reporting (and to Who) |
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| PMH | Patient Screening & Chronic Disease Delivery Program | To improve patient access: Data collected monthly for physicians and patient care team staff | Health Information Coordinators and Research & Evaluation Consultant (REC) | Time to third next available appointment (TNA) | Yes, mandatory | Monthly to management and Board; annually to physician members, staff, and community |
| PMH | Patient Screening & Chronic Disease Delivery Program | To improve patient access: Data collection daily by patient care staff | PCRNs, PCRPs, REC | Utilization of patient care teams (type of patient encounter; average number of encounters, number of no shows) | No | Monthly to management, staff, and Board; annually to physician members, staff, and community |
| PMH | Patient Screening & Chronic Disease Delivery Program | To improve patient experience | REC (collect, analyze and report); PCRNs and PCRPs (engagement patients to participate) | Patient rating of care using a patient experience survey (adapted from CIHI, AHRQ, and AH); Patient Care Team only (not physician) | Yes, mandatory | Annual to management and Board; annually to physician members, staff, and community |

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| PMH | Patient Screening & Chronic Disease Delivery Program | To Improve patient's ability to self-manage their health conditions | REC, PCRN | Patient rating of level of confidence about managing health condition | Yes, not mandatory | Annual reporting to physician members, staff, and community |
| PMH | Patient Screening & Chronic Disease Management Program | To increase the use of care planning: Standardized improvement plan menu with three areas of focus; paneling, screening and chronic disease management, and support for mental health | PCC, HIC PCRN, PCRP, QI Consultant; EMR Project Lead | Number and type of improvement goals | Yes, not mandatory (capacity for improvement and organized and evidence-based care) | Monthly to management and Board; annually to physician members, staff, and community |
| PMH | Patient Screening & Chronic Disease Management Program | To improve patient outcomes: ASaP screening maneuvers are implemented as appropriate based on patient populations. | PMHCs, QIC | Number and type of patients screened: (note the HQCA annual report data is used for annual reporting) | Yes, mandatory (organized and evidence-based care) | Monthly to management, staff, physician members, and Board; annually to physician members, staff, and community |
| PMH | Patient Screening & Chronic Disease Management Program | To improve population health | REC, QIC | Per cent of patients admitted to hospital or visit and emergency department (use HQCA report) | Yes, not mandatory | Annually to physician members, staff, and community |
| PMH | Patient Outcome Measurement Program | To improve team collaboration: data collected annually using the CIHI survey to the physician and PMH team | REC (implementation, analysis reporting); PMH teams, physician members (participation in survey) | Health Team Effectiveness Score for each clinic | Yes, mandatory | Annually to physician members, management, and staff |
| PMH | Patient Outcome Measurement Program | To monitor the transition to PMH; use the adapted Patient Medical Home Assessment Rubric | REC (implementation, analysis reporting); PMH teams, physician members (participation in survey | Overall score on self-rated physician instrument | No, not mandatory | Annually to physician members, management, and staff |

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| PMH | Patient Outcome Measurement Program | To increase the transition to PMH | Physician Liaisons QIC | Change (number and per cent in PMH) in membership type (movement toward Enhanced or Comprehensive) | No, not mandatory | Semi-annually to the management, Board |
| PMH | Patient Panel Program | To increase the number of physicians that panel and participate in CII/CPAR; use the CII/CPAR readiness instrument to determine when paneling was completed, and live status to determine complete for CII/CPAR | HICs, QIC, Physician Liaisons | Monitor number of physicians that are in the process of paneling, number refused, and number completed<br>Monitor the number of physicians that are in the process of submitting data to CII/CPAR, number who are active, and number refused<br>Have used HQCA reports for continuity reporting as well | Yes, mandatory (panel and continuity) | Monthly to management and Board; annually to physician members, staff, and community |
| PMH | Patient Screening & Chronic Disease Management Program | To improve patient care planning by understanding patient population (panel) | HIC, QIC, Lead Measurement Consultant | Number of Enhanced and Comprehensive members who receive a panel/discovery report annually | No, not mandatory (internal reporting only) | Annually to management and Board |
| PMH | Patient Outcome Measurement Program | To improve patient outcomes and the management of patients with chronic disease | PCRN, PCRP complete clinical decision support tools; HIC, Lead Measurement Consultant and Measurement Analyst support team with regular feedback on compliance with the use of clinical decision support tools for chronic disease. | Per cent of patients managed as defined by evidence informed indicators<br>Per cent with gaps in best practice<br>Change in biomarkers for patient included as part of improvement goals | No, not mandatory | Annually to physician members, staff, and community; ad hoc to physician members when required for clinic-based improvement activities |

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| PMH | Patient Outcome Measurement Program | To determine the system impact for patients within a PMH where specific improvement goals have informed care delivery | Lead Measurement Consultant and MA | Cost impact study | No, not mandatory | Upon completion of project, within three-year business plan period |
| CSTI | Primary Care Centre | To provide coordinated 24-hour, seven-day-per-week management of access to appropriate primary care services | MOA (data collection); MA (analysis and reporting) | Number of referrals to PCC; number of CWC PCN<br>Physicians referring;<br>number of booked appointments<br>Reason for referral | Yes, mandatory | Monthly to management and Board; annually to physician members, staff, and community |
| CSTI | Primary Care Centre | To provide a central access point to primary care, 365 days a year | Lead Measurement Consultant and MA | Number of patients seen<br>Patient experience | No, not mandatory | Monthly to management and Board; annually to physician members, staff, and community |
| CSTI | Health Equity Program | To support the provision of comprehensive family practice at clinics within the CWC PCN catchment area that serve unique patient populations | Manager of Finance | Number of patients directly supported by PCN funds | No, not mandatory | Quarterly to PCN from health equity clinics |
| CSTI | Senior Services Program | To provide specialized primary care with the goal of supporting seniors to remain in their homes and communities for as long as possible | Lead Measurement Consultant and MA | Number of patients served<br>Patient experience<br>QoL measurement | No, not mandatory | Monthly to management and Board; annually to physician members, staff, and community |

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| PMH and Governance and Central Allocations | Completion of the Annual Report Schedule B evaluation categories | Completing indicator sets outline in Schedule B including TNA, Patient Experience, Screening, Governance, Leadership, Team Effectiveness, PMH Readiness | HICs and REC, Quality Improvement Consultant, Governance and Policy Lead, Manager of Governance & Organizational Operations | Alignment with Schedule B | Yes, mandatory | Monthly to management and Board; annually to physician members, staff, and community |
| Governance and Central Allocations | Board Governance Program | To improve the Board's ability to govern and to understand the uniqueness of their role | Manager of Governance & Organizational Operations, Governance and Policy Lead, Board Governance Coordinator | Accreditation Canada Board Self-Assessment<br>Annual Board Chair Assessment<br>Board Meeting Survey Data and internal analysis | Yes, mandatory | Monthly to Board (meeting survey data); annual to Board for Board assessment and Board Chair assessment, triggering the development of an improvement plan |
| Governance and Central Allocations | Human and Financial Resource Planning and Deployment Program | To improve the employee experience while achieving organizational excellence | HR Manager, Finance Manager, Manager of Governance & Organizational Operations | Leadership indicators including annual Administrative Lead Performance Appraisal, and an independent employee engagement assessment | Yes, mandatory | Annually to management and Board |
| Governance and Central Allocations | Policy and Risk Analysis Program | To mitigate organizational risk across all business units and foster a culture of excellence and inclusivity | Governance and Policy Lead, Policy and Procedures Coordinator, Manager of Governance & Organizational Operations | Audit and evaluation of employee acknowledgement and policy compliance via policy portal<br>Risk register subject to bi-annual reviews by all departments<br>Semi-annual reporting to Finance Audit & Risk Committee and Board | No, not mandatory | Semi-annually to management and Board |

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| Governance and Central Allocations | Privacy and Information Technology Program | To improve safeguards in protecting organizational information and strengthen IT service delivery | IT Business Analysts, Privacy Governance Advisor, Manager of Governance & Organizational Operations | Measure and evaluate privacy incidents through incident reporting software tool<br>Measuring per cent of employees who completed annual privacy training and exam<br>Quarterly reports from IT service provider on themes and numbers of IT service desk ticket requests | No, not mandatory | Quarterly and annually to management and Board |
| Governance and Central Allocations | Fund Development Program | To diversify and increase funds available to CWC PCN that can be invested in programs and services | Grant Writer, Manager of Governance & Organizational Operations | Percentage of successful grants obtained | No, not mandatory | Quarterly and annually to management and Board |
| Governance and Central Allocations | Communications | To improve communication with key stakeholder groups | Communications Advisors,<br>Communications Coordinator,<br>Marketing Specialist, and<br>Physician Liaisons | Social media engagement<br>E-newsletter open rates and click-through rates<br>Number of subscribers/followers | No, not mandatory | Quarterly and annually to management and Board |
| MSE | Community-Based Supports Program | To ensure that physicians and patients have seamless access to community-based programs and services and enhance the timeliness and effectiveness of care provided | | Number of partners<br>Patient experience<br>Physician satisfaction | No, not mandatory | Quarterly and annually to management and Board |

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| MSE | Clinic Engagement Program | To ensure clinic managers and staff are active, supportive partners in the development of PMH | | Number of engagement opportunities offered to clinic managers/staff<br>Clinic managers/staff level of engagement<br>Clinic managers/staff understanding of PCN programs, services, priorities<br>Clinic managers/staff satisfaction with PCN | No, not mandatory | Quarterly and annually to management and Board |
| MSE | Physician Engagement Program | To ensure member involvement in improving current and shaping future programs and to ensure high levels of engagement across the membership | | Number of engagement opportunities offered<br>Physicians' level of engagement in engagement opportunities<br>Net Promoter Score | No, not mandatory | Quarterly and annually to management and Board |
| MSE | Membership Model Management Program | To effectively manage the lifecycle of physician membership, ensuring positive member experiences | | Number of new members<br>Number of end-dated members<br>Proportion of members in each membership type and change over time<br>Members' satisfaction with membership type | No, not mandatory | Quarterly and annually to management and Board |
| MSE | Practice Support Program | To provide members with resources and services to help with their everyday practice and support compliance with regulatory bodies | | Members' satisfaction with services/supports<br>Utilization of services/supports | No, not mandatory | Quarterly and annually to management and Board |

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| MSE | Physician Continuing Medical Education and Professional Development Program | To provide members with learning opportunities in alignment with PCN objectives | | Number of CME & PD events offered<br>Members' participation in events offered<br>Members' satisfaction with events offered | No, not mandatory | Quarterly and annually to management and Board |