Primary Care Network CHINOOK

Chinook PCN Annual Report

2023
2024

Vision

A diverse population living healthier, fuller lives, receiving exemplary patient-centered primary health care delivered by engaged, integrated teams.

Mission

We collaborate with physician clinics, community partners and Alberta Health Services to optimize the delivery of accessible, exemplary, patient-centered primary health care.

Greetings CPCN members, partners and patients.

We are pleased to bring you the April 2023 – March 2024 Chinook Primary Care Network (CPCN) Annual Report. Whilst being incredibly proud of each of our Annual Reports, we have listened to feedback that the text heavy template we complete each year may not be the most user friendly. With this in mind, we have worked to create a different format that we hope you will find more compelling and meaningful.

Andrea Schultz
Executive Director

Dr. Chris Waller
Medical Director

Entering 2023-2024, the CPCN embarked upon Network-wide engagement and review as we prepared our 2024-2027 Business Plan. This work, coupled with the release of the Modernizing Alberta's Primary Health Care System (MAPS) report led us to ask tough questions internally of our evaluative processes, governance structure and how the CPCN fits into the changing landscape of Primary Care delivery in Alberta.

This review process led us to discontinue our Clinical Data Assessment (CDA) process, a mainstay of our evaluative work for over a decade. This decision allowed us to instead pursue a 'clinic directed' approach to data collection and evaluation, enhancing clinics ability to focus on the clinical areas that best suit their patient needs. In addition, a partnership with the University of Alberta has enabled us to utilize their EPIQ tool and is ensuring Quality Improvement (QI) can flourish at a clinic level.

From a governance perspective, our board recognized that their existing structure is not conducive to optimal governance as our Network continues to grow. They have taken the decision to reduce their size, cutting the number of physician members and increasing the number of public members to provide the widest possible input.

Our physician, NP and participating clinic panel numbers have increased over the last twelve months, bucking the trend of many other PCNs in Alberta. Our total patient panel saw a rise for the first time since the pandemic and our CII/CPAR (Community Information Integration and Central Patient Attachment Registry) registration number recently crossed 80% of potential clinical providers.

It is impossible for any written document to fully highlight the breadth of work being undertaken across our Network. The decentralized model that we utilize means that the staff we fund are fully integrated into their clinics and the work that they undertake makes a difference to Albertans on a daily basis. Reading the Annual Report as leaders within this organization fills us with pride for all that our teams are able to accomplish, we hope this new way of presenting the report allows more of you to experience this sensation.

Table of Contents

What is the Chinook Primary Care Network?

Primary Care Networks (PCNs) represent the collaboration between local physicians and Alberta Health Services, working alongside nurses, mental health therapists, pharmacists, physiotherapists, social workers and other health professionals to meet the everyday health needs of patients in the communities in which they live and work.

PCNs develop programs and services to improve access to care, cut wait times for specialists and reduce healthcare costs. Network clinic teams are provided the resources needed to promote patient self-care management. Unattached patients are identified through data analytics, increasing patient continuity of care.

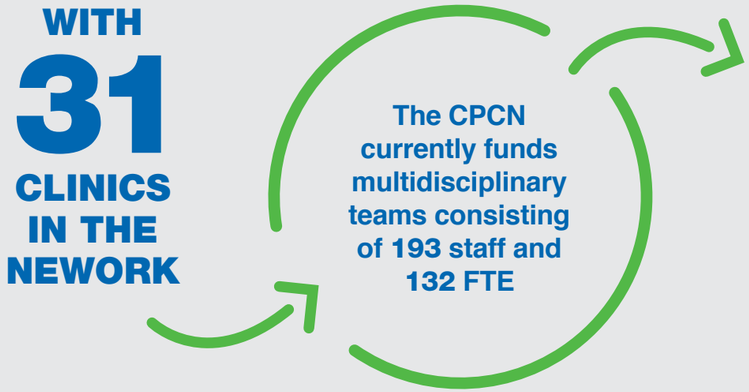
Research shows that patients who have a continuous relationship with a family doctor and team stay healthier as they age and live longer. They receive better care, make fewer visits to emergency rooms and are hospitalized less. Your family doctor and your PCN are working together to give you and your family a home base for a healthier future.

Since 2005, the Chinook Primary Care Network (CPCN), located in Lethbridge, Alberta, has represented the collaboration between local physicians in the Southwestern Alberta area and Alberta Health Services. The CPCN includes the City of Lethbridge, over 40 towns and villages, rural areas, the Piikani and Kainai Nation reserves, and approximately 50 Hutterite colonies.

The Chinook PCN operates in a decentralized model, with the multidisciplinary family practice teams providing direct patient care within the participating clinics. The Chinook PCN Central Support team collaborates with the teams in each CPCN-participating clinic to assist them in meeting the needs of the unique population that they serve.

There are 137 participating physicians in the CPCN, along with 11 Nurse Practitioners, providing care to just under 170,000 regional residents. The Chinook PCN has just under 211,000 residents within its geographic area. Approximately 50% reside in Lethbridge, and approximately 40% reside in rural areas with a population of 10,000 or less.

Physicians in Alberta work within privately owned clinics or Alberta Health Services. Almost all clinics within the region are members of the CPCN and are provided funding to build their own multidisciplinary teams who work together to optimize the delivery of patient care.



Priority Initiatives

The Chinook PCN is guided by Priority Initiatives set out in the 2021-2024 business plan. The CPCN identified four Priority Initiatives that inform the plans and actions for the CPCN over the course of the 3 year cycle.

PRIORITY # 1

Attachment & Increased Access to a Patient-Centered Medical Home Team

The foundation of the Chinook PCN is the concept of a Patient-Centered Medical Home, with the fundamental aim being applied Quality Improvement to increase access to high quality, evidence-based care provided by multidisciplinary Primary Care Teams. Access and efficiency measures both inform and influence processes to increase access and focus on clinical measurement indicators to inform delivery of evidence-based care in the Medical Home.

PRIORITY # 2

Team, System, Community and Patient Capacity Building

Southwestern Alberta has a large number of health care services available and Chinook PCN is well positioned to enhance capacity within these services. Chinook PCN improves capacity with clinics teams by responding to gaps in knowledge, communication and teamwork. We increase capacity of clinics, Alberta Health Services (AHS) sites and community partnerships by increasing communication, care coordination and integration between these different sectors to improve continuity of care. We act as a driver and change agent in the development of relationships and formalization of effective linkages amongst all parties and enhance system capacity. We promote patient partnerships with health care, strengthening knowledge of patients and clinic teams on the importance of patient-centered care, patient self-management and advocacy.

PRIORITY # 3

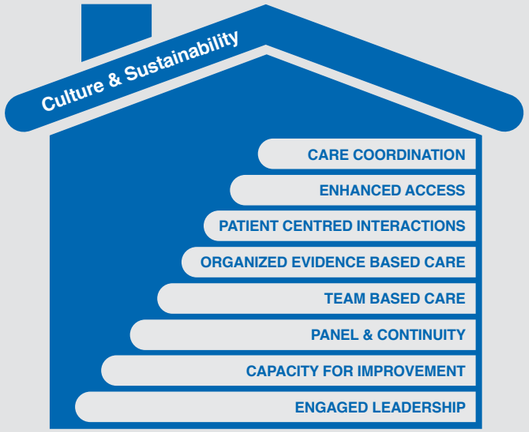
Measurement & Evaluation through Effective Information Management

The Chinook PCN has focused on measurement for improvement since its initial years and has been committed to the collection and evaluation of data. We measure evidence-based clinical indicators and expand to include patient and provider experience and continually assess the needs of the population and communities that we serve.

PRIORITY # 4

Governance & Accountability

The Chinook PCN recognizes the importance of strong vision and leadership. During the 2015-2018 Business Plan cycle, we implemented a Network-wide Chinook PCN Charter, which clearly outlines the guiding principles and defines the responsibilities for participating physicians and clinics. The elements of the Charter acknowledge that we are stewards of public funds and that we are accountable to the population that we serve. The PCN has implemented various accountability measures and policies to support adherence to elements of the Charter.



Clinic Enablers • PCN Supports • System Level Supports

Attachment & Increased Access to a Patient-Centered Medical Home Team

HEALTH CARE PROFESSIONALS

Multidisciplinary Teams:

Who are they?

Within the CPCN, multidisciplinary teams consist of Nursing disciplines including LPNs, RNs and NPs. There is also a complement of Social Workers, Pharmacists, Mental Health workers, Physio Therapists and a Breast Feeding Specialist.

What do they do?

Multidisciplinary teams work to support and promote the Patient's Medical Home Model, and provide care for a defined panel of patients, reduce delays for and at appointments through increased office efficiencies, coordinate new and value-added services including screening, prevention, treatment and management for patient care needs.

HIGHLIGHT

Patient's Medical Home - Clinical Care Coordinators:

Embedded in the Network's participating clinics, Clinical Care Coordinators (CCCs) partner with and are supported by Primary Health Care Integration Leads to strive towards the full implementation of the Patient-Centered Medical Home and all Network initiatives. Currently, the CPCN has 26 CCCs (plus 2 clinics actively recruiting as of March 31, 2024). CCCs have nursing designations and provide clinical care and are responsible for case management and coordination of care across multidisciplinary family practice teams. CCCs are a critical link for information, acting as the point of contact to distribute all information. CCCs continue to play an important role in amending and implementing policies and procedures including those related to the Chinook PCN Priority Initiatives as well as maintaining regular clinic activities. Balancing changing guidelines and continuing to support patients with an accessible Medical Home has been a priority for CCCs.

HIGHLIGHT

Health professional - Clinical Social Workers

The Social Worker collaborates with primary care patients, physicians, interdisciplinary team members, and community partners to connect patients with resources to assist with meeting basic needs such as food, clothing, housing, medication, transportation, and social integration. Currently, 8 CPCN clinics have a Social Worker as part of their multidisciplinary team.

Participating in a Social Worker Community of Practice allows these specialized allied health professionals time and space to network around resources, skills, and ideas.

.

IMPROVING QUALITY AND SAFETY

EPIQ

The CPCN supports Quality Improvement (QI) work by providing training using the University of Alberta Evidence-based Practice for Improving Quality (EPIQ) Tools. EPIQ is a full day workshop that builds a team's understanding of Quality Improvement using a series of evidence-based tools in 10 steps. The CPCN Quality Improvement team became certified facilitators in 2023 and have completed 4 trainings with intact clinic teams, and 4 open trainings with mixed teams. The over 80 participants have included physicians, nurses, MOAs and receptionists. Delivering workshops in-house has developed a common, shared QI language throughout the Network to focus on what can be done, and what they want to accomplish as a whole. This has also encouraged clinics to speak to and work with each other sharing, spreading, and scaling up the QI work and improved practice.

HIGHLIGHT

PLP partnership and the Taber Clinic, Integration Leads

QI work is supported by the Central CPCN QI Team which includes 3 Integration Leads (ILs). The ILs are equipped to support clinics in the application of Office Practice Redesign principles and other QI methodologies and provide support to identify ways to optimize the delivery of primary health care and social services in a coordinated way. All ILs were trained in EPIQ facilitation and have assisted clinics in leading QI projects across the Network.

The Chinook PCN is collaborating with Physician Learning Program (PLP) Edmonton and the Office of Lifelong Learning (L3) to support building sustainable quality improvement infrastructure and help physicians and their teams advance practice. Through ongoing work with the PLP, CPCN has adapted workshop tools to supplement and complement existing procedures, and co-created communication tools to support Physician Practice Improvement Program requirements (PPIP) and connect them with ongoing CPCN QI work.

The Taber Clinic was the first in clinic EPIQ workshop, which included physicians and large complement of clinic staff. Working closely with the Integration Lead and other team members, the clinic was able to identify supports and barriers to create a plan for implementing the project over the following year.

COMMUNITIES OF PRACTICE

The CPCN strongly believes that no one is an island and that knowledge sharing and learning are important parts of creating safe and quality health care teams. Within the CPCN, there are multiple Community of Practice (CoP) meetings, which are held regularly to improve knowledge and idea sharing. Meetings with these groups provide peer support and guidance as needed as well as assisting with recruitment. These include:

- Nurse Practitioners
- Clinical Care Coordinators
- Social Workers
- Information Management and Panel
- Weight Management

HIGHLIGHT

Community of Practice Highlight: Nurse Practitioner CoP

One of the newest CoPs is the NP Community of Practice. This group meets quarterly and allows NPs the opportunity to network and have included presentations on Diabetes management and prenatal care. These meetings give the 11 NPs opportunities to share accomplishments, barriers, and knowledge. The NP CoP is co-chaired by an NP and the Clinical and Quality Improvement Lead.

About Greg's Wings and the I Saved a Life Campaign

The Chinook PCN is very fortunate to have a strong partnership with the Price family and the Greg's Wings Project promoting patient safety and system change through "Falling Through the Cracks" screenings and discussions. These screenings have led to robust conversations focused on identifying gaps in the system and supporting projects within clinics to prevent patients from falling through the cracks. In 2023, the CPCN coordinated two "Falling Through the Cracks" screenings, presented to a conference in October 2023 Fellowship for Health System Improvement (U of A) in collaboration with the Price family, and used teaching scenes that accompany the film at a Clinic Retreat to increase awareness of the importance of communication with and between teams and patients. An in-person screening of "Falling through the Cracks" at the annual Family Practice Summit in March 2024, was well attended. Following the usual screening, the participants worked with Dave and Teri Price using teaching scenes to provide further education on recognizing errors and prevention strategies.

Primary Care is a long-term investment, and everyone has part to play to improve life-saving efforts. The **"I Saved a Life"** campaign was created to acknowledge the efforts from all positions within the primary care system. This campaign shares stories where patient health, clinic processes, and/or patient safety have been enhanced by seemingly small, yet extraordinary actions. The CPCN hosted three I Saved a Life presentations and showcased a story at the beginning of each board meeting.

14 stories were shared, highlighting 22 individuals, including MOAs, reception, booking clerks, LPNs, RNs, Physicians, Nurse Practitioners, Social Workers, as well as external partners such as the AMA. Stories of patient advocacy and process change were among the highlights.

HIGHLIGHT

Greg's Wings award 2023: *In collaboration with Greg's Wings Foundation, the CPCN created the Greg's Wings Awards. These two awards, Individual and Teamwork, are based on criteria from the Greg's Wings Organization – culture of teamwork, access to information, and learning from failure/learning health system. All I Save a Life Stories are nominated for this award every year. The two I Saved a Life winners were recognized with the Greg's Wings awards, presented by Dave and Teri Price at the CPCN Family Practice Summit in March 2024.*

TIMELINE OF I SAVED A LIFE

Ideas simmering

Spring 2019
Falling Through the Cracks for the first time

March 2020
Falling Through the Cracks at Family Practice Summit

January 2021
Beth's story

I Saved a Life is born & grows

Summer 2019
Shawn Achor and Brene Brown

Rest of 2020
Development and presenting Happiness Works

March 2021
I Saved a Life endorsed by board and launched at Family Practice Summit

Maintaining the Momentum

Rest of 2021-Present
Regular ISAL updates at board and live presentations

March 2022
Creation and presentation of Greg's Wings awards

March 2023
Presentation of 2nd annual of Greg's Wings awards

Spring 2023
Expansion of ISAL Presentations at clinic meetings encouraging peer recognition

Team, System, Community and Patient Capacity Building

PARTNERSHIPS WITH AHS

The ability to form and work within partnerships continues to be a foundational part of the CPCN work. The ongoing partnership with Alberta Health Services is integral in the ongoing care of both paneled patients and patients within the community. Strengthening medical neighborhood teams and establishing effective communication between Community Programs, specialists, PCN Clinics, and AHS has been a priority to promote Home to Hospital to Home transitions. The CPCN works with clinics and AHS Public and Primary Health Care to develop screening tools to identify patients with complex needs and work in partnership with external organizations to appropriately meet and integrate the patient into services within the community.

Lethbridge Unattached Patient Clinic (LUPC): In 2022, the CPCN supported the creation and implementation of an unattached clinic within AHS. This clinic supports patients who are not attached to a family physician but require follow-up care from hospital discharge or discharge from other programs. The CPCN continued to support this work through 2023/24 and funds an RN position in the clinic. The LUPC received an average of 67 referrals per month from November 2023 to March 2024.

Shared Mental Health/Behavioral Health Service: The CPCN works closely with AHS partners in the provision of Shared Mental Health (SMH) Services to 19 clinics within the CPCN and provided care to over 1500 unique patients in 2023/24. The combined service offers clinics access to a Mental Health Clinician within the medical home, offering both in person and virtual services. Three new clinics started receiving this service in the last quarter of 2023/24 year. The SMH team and the CPCN began work on a pilot project, intended to work closely with the Addiction and Mental Health (AMH) team already located in Crowsnest Pass, to offer services in clinic and increase service availability. The pilot remains in the planning stages which include representatives from the AHS AMH team, SMH team, Crowsnest Medical Clinic and the CPCN central support team.

Pelvic Floor Physiotherapy: The CPCN funds a 0.9 FTE Physiotherapist (PT) who specializes in Pelvic Floor and works in partnership with the Pelvic Floor Clinic at the Chinook Regional Hospital. Serving CPCN patients who do not have private coverage, the PT runs group classes and provides individual services as needed. In 2023/2024, the Pelvic Floor PT received an average of 28 referrals per month over the course of the year, with an increase in the last quarter average 39 referrals per month. 94% of all referrals were referred directly to the group class. The remaining referrals were triaged to other appropriate services.

Events: In order for the various primary health care providers to remain competent and current in their provision of clinical care, there must be investment in ongoing education and training. The CPCN encourages clinics to actively participate in development activities to encourage clinic team development, including Clinic Showcase and Family Practice Summit.

CLINIC SHOWCASE

The CPCN hosted the third Clinic Showcase in November 2023. There were 77 participants from 22 clinics including 13 physicians. Presentations included a full circle discussion of what was done since last year's showcase, including the EMR networking group that was struck and access improvement in a rural clinic, both of which were based on the 2022 Showcase discussion.

Clinic presentations included use of STI Self Screening, using team to enhance access for prenatal care, NP provided pre- and post-natal care in clinic and providing prenatal care in Primary Care presentation by a OB physician. This year also included presentations from outside organizations including Cardiovascular Risk Screening Tool, Social and Immigrant Services offered in the community, Lifestyle programs offered in clinic and in community, and utilizing residents in Primary Care Clinics. Co-presentation on Addressing the Social determinants of health in clinical practice included Social Worker role and presentation of Reducing the Impact of Financial Strain screening tool. The CPCN Central Team led brainstorming session on learnings from the day and how to get started in clinic using QI tools.

FAMILY PRACTICE SUMMIT

The CPCN continued to host the Family Practice Summit as an annual event for all staff and physicians in March 2024. The event theme this year was Together for Y(Our) Health and included a screening of "Falling Through the Cracks" and discussion with the Price family, a Poverty Simulation, presentations from local specialty groups, a panel discussion with different physician roles in the Network including Provincial Leadership, AHS, AMA and Indigenous Health. The Keynote speaker was the inspiring Chris Koch and his "If I Can" topic on not letting limitations stop us. 24 Family Physicians and 138 clinical staff attended from 25 clinics, the CPCN central support team as well as 19 Community and AHS organizations.

Spirit of the Hive: Every year, the CPCN recognizes one individual who is nominated by their peers for the Spirit of the Hive award. This award recognizes outstanding contributions to the CPCN and is awarded on an annual basis at the Family Practice Summit. It was first awarded to Dr. Clayne Steed in 2014, after approximately 9 years of service to the Chinook PCN. When faced with complex decisions at Finance and Audit Committee, or at Leadership Committee (now the CPCN Ltd. Board of Directors), Clayne would often say, "In the Spirit of the Hive, (insert one of several wise recommendations here)". Clayne's wisdom, strong ethics and insight into the collective needs of all Network participants, inspired the creation of this award.

> "In the Spirit of the Hive, (insert one of several wise recommendations here).

This year's winner was the Clinical Care Coordinator from The Associate Clinic in Pincher Creek, Cheryl Dolan. Cheryl was highlighted by her clinic as she:

- Created the future of healthcare in the province.
- Established interdisciplinary teams in primary care.
- Part of published research, building the greater hive through the international community.
- "Generalist specialist" with knowledge and experience that encompasses most spheres in health care.
- Guiding force in CCC peer group, nurtures the next generation of healthcare professionals.
- Collaborative approach to care that extends beyond clinic walls – her hive is the whole community.

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

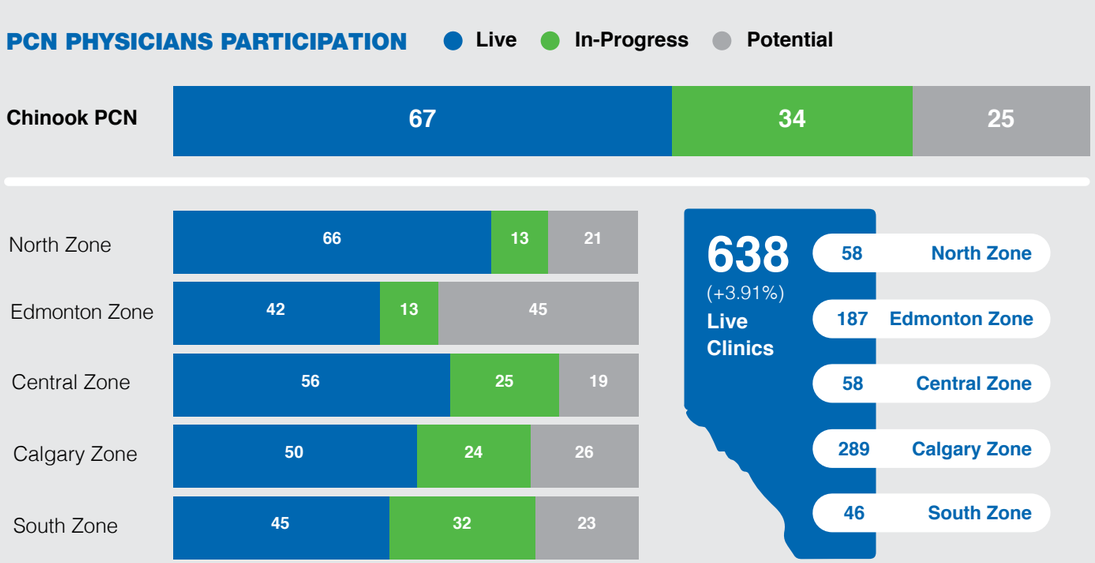
The CPCN team continues to support clinics to enroll in the CII/CPAR program, supporting panel management processes and enabling the tools and processes of this provincial system. In April 2024, the CPCN reached the provincial goal of 80% of physicians with either live or in the process of going live on CII/CPAR. 73 physicians and nurse practitioners are live on CII/CPAR. 12 live PCN member clinics, 4 confirmed, 2 enabled, 1 scheduled to go live. The CPCN offers support for clinics who have signed on to CII/CPAR to optimize the use of information such as:

- E-Notification: Use of the Hospital Discharge Program created by a local clinic.
- Supporting Panel Managers on panel clean-up using Panel Attachment Conflict Report and Patient Demographic Mismatch Report.

WHY CII/CPAR MATTERS:

The CII/CPAR program allows patient information to be shared between clinic EMRs and Netcare. CII enables communication across the health care system. This allows other community clinics, specialists, emergency and acute care to know who the patients is paneled to and what they have been seen for. In addition, clinics receive information on patients including deceased patients, errors between their EMR and Alberta Health and patients who are paneled to other providers anywhere in the province allowing for clean panels. One clinic CCC stated "CPAR allows us to see if patient's have moved away and are being cared for another provider in another Network". The CPCN is leading the zone in CII/CPAR participation, with the largest barrier for clinics to join CII/CPAR being EMR compatibility.

PCN PHYSICIANS PARTICIPATION



ONE CLINIC CCC STATED

> "CPAR allows us to see if patient's have moved away and are being cared for another provider in another Network

RIFS INITIATIVE:

Combining the IT expertise of the CPCN central support team with the knowledge base in public and population health, the CPCN Senior Advisor was able to create a digital RIFS (Reducing the Impact of Financial Strain) screening tool. This tool and project is expanding across the Network, demonstrating significant benefit for both patients and providers.15 clinics are involved with the RIFS project, connecting more than 600 patients with financial resources. The RIFS project was presented at the provincial PCN Forum where 11 PCNs and Zone committees connected with the CPCN Senior Advisor to learn more and asked to use RIFS tool in their area. The CPCN is supporting clinic teams to build processes that leverage the RIFS assessment with existing team members, ranging from patient self-serve models to Social Work referral pathways. The CPCN is currently assessing opportunities for provincial scalability of the RIFS tool.

- Clinics adopt either a "staff-driven approach" or a "patient-driven approach" for screening. Staff-driven approach involves healthcare professionals asking patients the screening question during consultations and offering support. Patient-driven approach entails patients accessing the RedCap survey independently through QR codes on posters and Health Unit Television. Lethbridge Family Medical adopted the patient driven approach and have hung posters in exam rooms and waiting rooms. In 1 year period, there 139 patients scan the QR code and get connected with financial resources. This approach has been an effective way for clinics with limited staff capacity and time to still connect patients with financial resources and foster a holistic understanding of patients' wellbeing.

COMMUNITY PARTNERS:

The CPCN recognizes that communication and connection between clinics and community partners is vital in the patient's medical neighborhood model and creates a closed loop for patient care. Lunch and Learns are offered virtually throughout the year and promote communication and collaboration with community programs and services to connect with clinics and clinic staff. All presentations are recorded and available for clinics staff to view.

Topics Included:

- Prescription to Get Active.
- Newcomers Health
- Reducing the Impact of Financial Strain
- Pelvic Floor Physio Program.
- Chronic Pain Clinic.
- Alberta Surgical Initiatives: Specialty Access FAST
- Local Community Paramedics Program
- Lethbridge Legal Guidance
- Social Prescribing
- Indigenous Wellness Core
- Low German Speaking Mennonite education session.

The CPCN, AHS and Community partners, co-hosted a full day Bridges out of Poverty event which highlighted local community organizations and considerations when working with low-income populations.

PRESCRIPTION TO GET ACTIVE

FAST: FACILITATED ACCESS TO SPECIALIZED TREATMENT

Lethbridge Family Services Since 1910

Measurement & Evaluation Through Effective Information Management

SUPPORTING CLINICAL QUALITY IMPROVEMENT

The Chinook PCN hosted a Cervical Cancer Screening Challenge throughout 2023, promoting awareness and promotion of cervical cancer screening for eligible women-recognizing that screening is a critical approach to reducing incidence and mortality. In March 2024, results were announced at the Family Practice Summit, with recognition given to top performing and most improved providers and teams. Across the CPCN, the top performing provider had completed screening for 88.1% of their panel with 709 paps completed. The most improved provider increased screening from 54% to 75% in one year. Overall, providers in the Chinook PCN completed over 23,312 pap smears, and continue to strive to offer screening to eligible women in our communities.

ACCESS AND ATTACHMENT

Access and attachment to a primary care provider is foundational to the Primary Health Care system. In 2023, the Chinook PCN continued to struggle with a shortage of primary care providers and unattached patients in the community. Physician recruitment continued throughout the year, with an increase from 124 to 137 physicians participating in the CPCN through the year. This increased number of physicians supported attachment for over 7000 patients in the Network, and reduced the number of unattached patients from over 49,000 to just over 41,000 in the year. CPCN continues to partner with AHS to promote recruitment of primary care providers, and support access to multidisciplinary teams to offer care to our patients

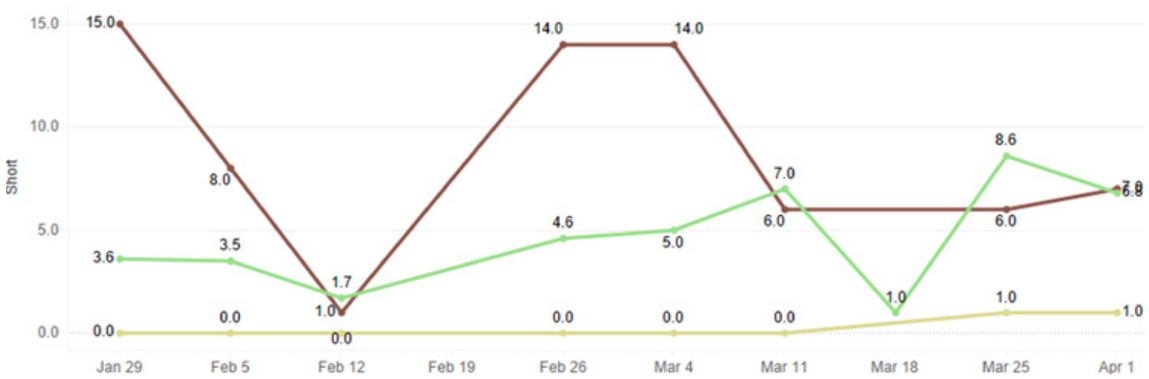
THIRD NEXT AVAILABLE DASHBOARD

Chinook PCN has long recognized that patients are best served by having timely access to their primary care provider. In 2023, the CPCN implemented a new platform to support efficient and consistent reporting of "third next available" appointments. This platform supports clinics to monitor and manage wait times, and also supports network wide trending and evaluation practices.

2023 CERVICAL CANCER SCREENING CHALLENGE

Top provider screened 88.1% of panel: 709 paps completed!

Chinook PCN - Third Next Available



Provider Experience Survey

The Chinook PCN conducts annual Provider Experience Surveys to understand the experiences of staff and physicians working in CPCN member clinics. The survey focuses on three main areas of provider experience:

- My experience
- Clinic Support
- CPCN Support

Results are reported to CPCN leadership and governance, as well as to clinic leadership where appropriate.

In 2023, 163 staff and physicians responded to the survey, with participation from 22 clinics and at least 10 clinic roles. Compared to 2022, a number of positive trends were noted, reinforcing the strategies and approaches used in the CPCN to support primary health care teams.

HIGHLIGHTED QUESTION	% Positive - 2023	% Positive - 2022	% Positive - 2021
Clinic applies the Patient Centered Medical Home model	89% (↑14%)	75%	89%
Clinic meetings provide an open, comfortable, safe place to discuss concerns	81% (↑11%)	70%	74%
Individuals are well-informed of the purpose and initiatives of the CPCN	89% (↑24%)	65%	77%
CPCN central support staff they interact with understand their challenges and unique circumstances	81% (↑24%)	57%	71%
Individuals feel their contributions to their clinic are recognized	91% (↑14%)	77%	80%
Individuals are satisfied with their job	91% (↑13%)	78%	86%

HQCA PARTNERSHIP

Health Quality Council of Alberta has supported primary care providers with "Panel Reports" since 2011, providing clinical and administrative data to physicians and nurse practitioners, clinics, and PCNs related to the care of their patients. HQCA is uniquely positioned in Alberta with access to provincial data, and provide unique insight into patient panels, including items such as how often primary care patients go to emergency, to immunization rates, to community characteristics such as social deprivation indices.

In 2023, Chinook PCN and HQCA engaged in a partnership to enable Network wide access and sharing of Panel Reports, aimed at leveraging the HQCA reports to support better patient care, and reducing overlap of evaluation efforts between HQCA and CPCN.

Using the information available from HQCA in combination with EMR and AHS based data collected by the CPCN Evaluation Team, clinics are supplied with robust information to make decisions, understand barriers, and act towards improving care for their communities.

HQCA Highlight: Social Deprivation Index. Social deprivation includes information related to relationship status such as separation, divorce and single-parent families by neighbourhood. Understanding social deprivation can help teams understand why patients may not fill medications, miss appointments, or have lower cancer screening rates. Where clinics identify barriers to care related to social concerns, they can adapt their care team to support patient concerns such as income security and build teams to include roles such as Social Workers who assist vulnerable patients to navigate complicated social services.

REFOCUSING EVALUATION

2023 was a period of planning for the future in Chinook PCN. The Board engaged in strategic planning for the 2024 to 2027 Business Plan and reflected on the impact of long-standing evaluation practices in the CPCN.

In June 2023, the Board decided to end the "Clinical Data Assessments" which had been a core evaluation activity since ~2007. The Clinical Data Assessments were recognized as a once-critical structure of the PCN, supporting consistent measurement and evaluation of screening and preventative care across the Network. As CPCN clinics have evolved and established high quality processes, and as HQCA has taken on an increasingly important role in reporting, the CPCN acknowledged the opportunity to focus our resources towards supporting front-line quality improvement, and to look towards other opportunities to develop CPCN's evaluation practices.

Looking at future evaluation opportunities, CPCN has initiated an Evaluability Assessment (EA). The EA is intended to assess core elements of evaluation, including context, capacity, data availability and "theory of change" (ie. how the PCN expects activities to drive outcomes). The CPCN engaged with an evaluation consultant team and created an Evaluation Advisory Group to drive the EA process. The Evaluation Advisory Group included diverse representation from physicians, managers, Clinical Care Coordinators, as well as representatives from the Central Support Team, who provided broad input and perspectives to assess evaluation opportunities and capability in the CPCN. The Evaluability Assessment will be presented to the CPCN Board in 2024 and will help build a foundation for a renewed Evaluation Framework, which will enable the PCN to adapt and evolve in our dynamic and changing environment.

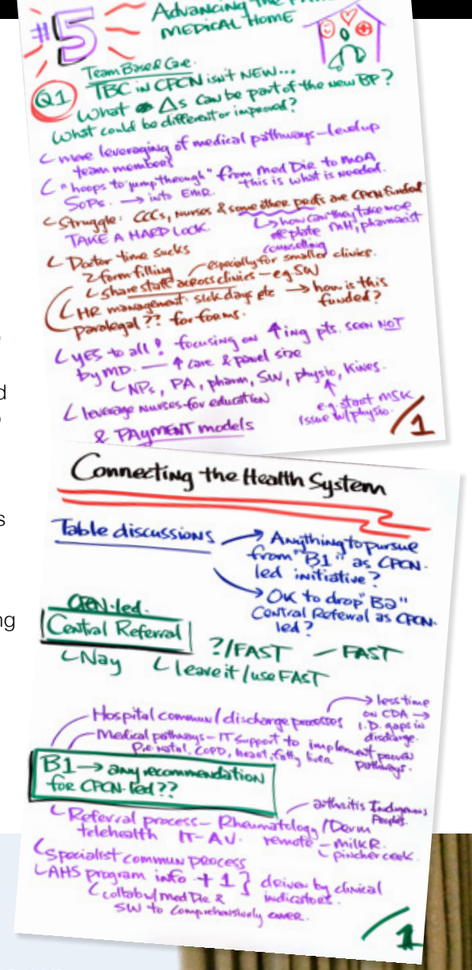
Governance and Accountability

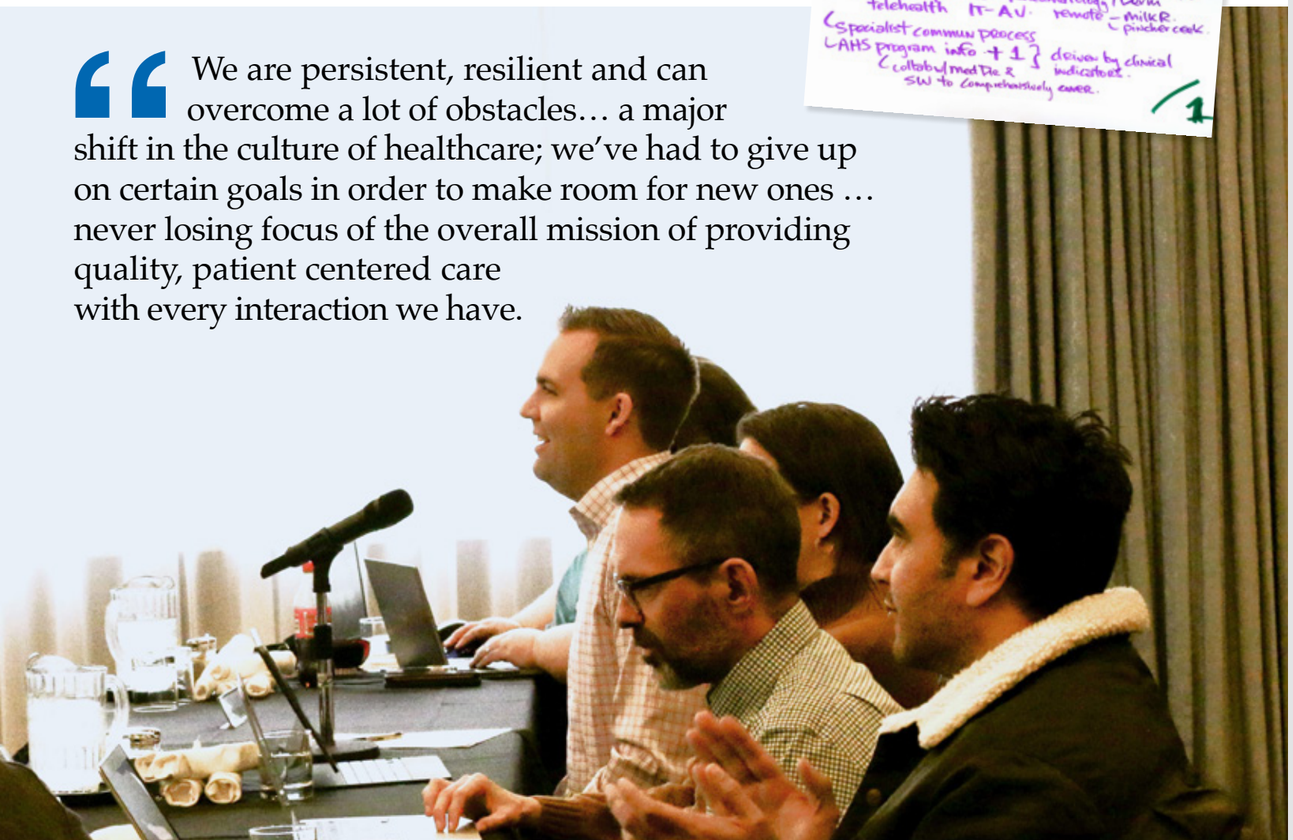
STRATEGIC PLANNING

In 2023, Chinook PCN engaged in strategic planning to enable creation of the 2024 to 2027 Business Plan. The team gathered input and feedback from Clinic Managers, Clinical Care Coordinators, members of the Central Support Team, and Board members through a variety of methods, including workshops, surveys, and in-person planning sessions. The collaborative approach to planning has resulted both a renewed strategic direction for the CPCN, as well as concrete actions to prepare CPCN to address changes in the health care system. The creation of a new priority initiative, “Sustainably improving equity for underserved patients” lays the foundation for the CPCN to adapt to a potential shift to population-based funding, and consider new models of care for vulnerable communities.

REDUCING BOARD SIZE, INCREASING PUBLIC MEMBERSHIP

In December 2023, the Board made a landmark decision to reduce the Board size and alter the composition of membership, enabling the board to prepare for changes in the healthcare system that will require nimble decision making. Guided by a Board Size and Composition Working Group, the Board approved a new model which focuses on balanced representation of urban and rural physicians and increases public membership.





“We are persistent, resilient and can overcome a lot of obstacles… a major shift in the culture of healthcare; we’ve had to give up on certain goals in order to make room for new ones … never losing focus of the overall mission of providing quality, patient centered care with every interaction we have.

Preparing for the future of the Chinook PCN

The Chinook Primary Care Network has a proud history of engagement and innovation and has adapted to a constantly changing environment over the 19 years of partnership with clinics and Alberta Health Services.

A renewed focus on primary health care, with direction through the Modernizing Alberta’s Primary Health Care System (MAPS) report, and the creation of Regional Primary Health Care Networks by Alberta’s government, means that a period of change is expected in the coming years. Chinook PCN has taken an active role in preparing for the future, with strong direction from the Board, close relationships with clinics and AHS partners, and increasing collaboration with community partners.

CPCN has continued to invest in capacity and structure to build quality and safety for patients. EPIQ training has laid a new foundation for quality improvement work, supporting staff, intact clinic teams, and physicians with a suite of tools and collaborative approaches to address evolving problems in our ever-changing environment. The lasting partnership with the Greg’s Wings foundation keeps the CPCN grounded in patient safety, and continuously focused on providing the highest quality and safety care.

CPCN has engaged in new initiatives that have reaped promising results and gathered provincial attention over the past year. The RIFS tool serves as another example of how the CPCN has taken a creative approach to a complex problem, learned from other PCNs, and set the stage for another provincial partnership to share tools with other PCNs. As evidence has become stronger related to the impact of social determinants of health, CPCN has continued to make advances to better serve vulnerable communities.

2024 promises to be a period of significant change for the healthcare sector, and CPCN has taken concrete steps to prepare through the renewed Business Plan, re-composition of the Board, and development of strong relationships with partners. In this dynamic and changing environment, CPCN will continue to prepare and adapt, while ensuring a focus on patient-centered care for the communities we serve.

Primary Care Network
CHINOOK

Alberta Government

ALBERTA MEDICAL ASSOCIATION

Alberta Health Services