2018

Report to the Community

Primary Care Network
EDMONTON WEST

Providing the best primary care to our community.

CONTENTS

180

PHYSICIANS PROVIDING CARE AND SUPPORT TO MORE THAN

178K

PATIENTS.

REPORT TO THE COMMUNITY 2017-18

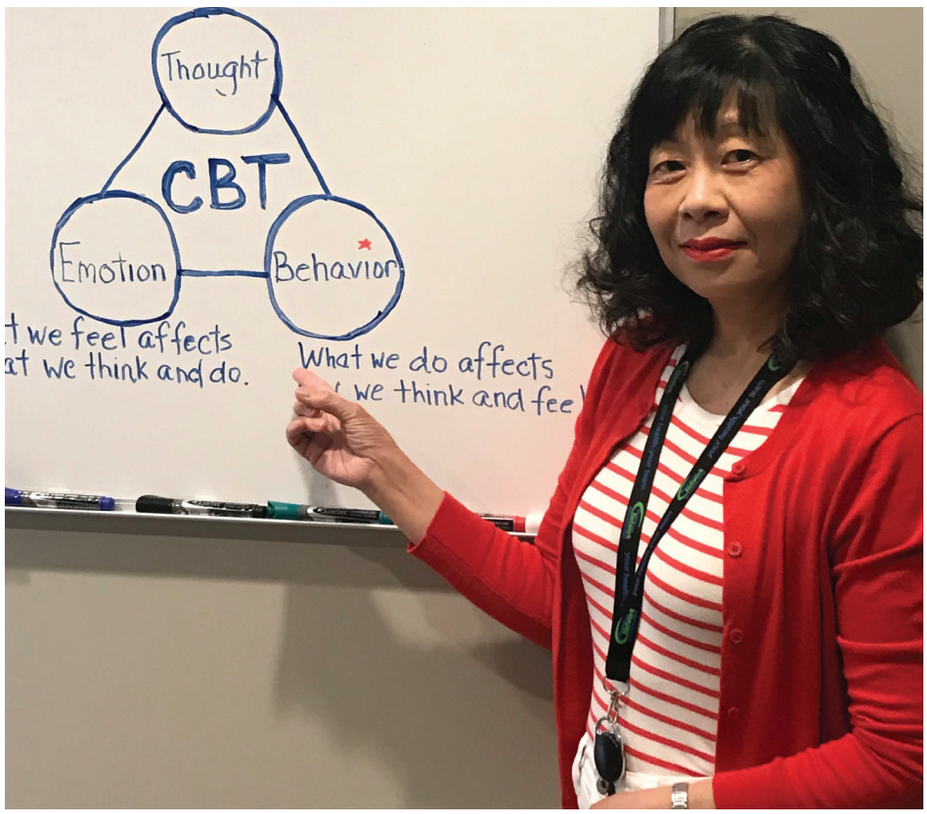
Providing the best primary care to our community

The Edmonton West Primary Care Network (EWPCN) is one of the largest primary care networks in Edmonton with over 180 physicians providing care and support to more than 178,000 patients.

Our family physicians are the key to our patients' medical home; providing them access to a dedicated team of health professionals who are passionate about caring for them through every stage of their life.

Our team of nurses, pharmacists, mental health professionals, dietitians, social workers, occupational therapists and exercise specialists work each day to keep patients living their healthiest life.

As a result, the Edmonton West Primary Care Network strives to enhance our health system by delivering the right care, in the right place, at the right time, by the right health professionals, with the right information.



MESSAGE FROM THE BOARD OF DIRECTORS

On behalf of the Board of Directors, welcome to Edmonton West Primary Care Network's inaugural Report to the Community.

After more than a decade in operation, we are experiencing the benefits that our established programs and services provide to patients in our community as we continuously look for opportunities to improve primary care.

Our work is about enhancing primary health care for people who live in west and southwest Edmonton through collaborative and innovative relationships.

The 2017-18 strategic priorities of the organization were affirmed in July, and this report highlights some of our achievements to date.

I am pleased to share that our medical home initiative is making tremendous progress as many member physicians are embracing the opportunity to continuously improve the comprehensive primary care services offered to their patients.

An integral part of the medical home is the vital care our nurses deliver in chronic disease management by working within their full scope of practice. This is a significant contribution to the care offered by our family physicians and interdisciplinary teams.

In addition, we highlight the collaborative work of our social workers who are critical to maintaining the continuity of care. Our social workers help patients navigate the health system or access essential community supports to improve their quality of life.

Through the medical home, patients are cared for by their family physician through every stage of life. The Frail Elderly Outreach program attends to the complex social and medical conditions of many seniors in our community.

Finally, our focus on prevention is evident with the great strides we have made in offering patients comprehensive assessments and minor wound care in the Lower Leg Assessment Clinic, which keeps people enjoying active, healthy lifestyles.

As one of the city's largest primary care networks, Edmonton West Primary Care Network continues to collaborate on Edmonton Zone initiatives like Prescription to Get Active and Find-A-Doc and we look forward to building on that success in the coming year.

In closing, I would like to acknowledge my appreciation to our partners; Alberta Health, our joint venture partners at Alberta Health Services, fellow Board Members and Committee Members, member physicians and our staff for their dedication to the health of our patients.

Together we provide the best primary care in our community.

Dr. Allen E. Ausford

Board President

MISSION VISION VALUES

Our mission is to support family physicians in improving primary care through relationships, collaboration and innovation.

Our vision is to provide the best primary care to our community.

WE VALUE

- INTEGRITY
- RESPECT
- COMPASSION
- BEING PATIENT-CENTERED

OUR BOARD

Dr. Doug Strilchuk *Past President*
Dr. Allen Ausford *President*
Dr. Steeve Boissinot *Director*
Dr. Dianne Brox *President Elect*
Dr. Brian Lee *Director*
Dr. Stephanie Liu *Director*
Dr. Brock Organ *Director*
Ms. Lara McClelland *Community Director*
Ms. Jennifer Fougere *Executive Director*
Dr. Wendy Dawson *Medical Director*

Missing: Dr. Maria Pariy, Dr. Jeff Shmoorkoff

GOALS

In five years, all our patients will be part of a medical home where they will be able to reliably access 24/7 primary care, have improved access to coordinated mental health services, have less need for specialist referrals and experience safer transitions of care. The EWPCN will accomplish this by achieving the following goals by:

1. Being leaders in facilitating attachment to a family physician for unattached patients.
2. Building capacity for patients to reliably access appropriate 24/7 primary care through their medical home.
3. Maximizing the capacity of primary care to respond to the needs of our patients by building and leveraging the skills of our family physicians.
4. Decreasing the burden of mental illness for our patients by increasing the capacity of the medical home to support mental health.
5. Improving the quality of patient care by supporting the adoption of current and effective clinical practices.
6. Reducing identified barriers to care within our community for vulnerable populations based on demographic data.
7. Partnering for zone-level solutions for safer and efficient transitions of care.
8. Partnering for zone-level solutions to improve access to specialist care.

welcome to your

MedicalHome

ACHIEVEMENTS

Our team-based care is offered through the medical home, at the family physicians' clinic and is enhanced with several primary care services offered centrally.

Our workshops, one-on-one appointments, the Low-Risk Maternity clinic, the Lower Leg Assessment clinic, and the After-Hours clinic are offered at the central office located in the Meadowlark Health and Shopping Centre.

Another support offered is our Pharmacy Discharge program where our pharmacists work closely with the primary care physicians to help patients during the transition between hospital and home.

Our Why Wait? program takes a collaborative approach to care for patients by helping them make the shift to more active and healthy lifestyles.

Perhaps our most significant advancement, this year, has been the progress we've made helping our family physicians enhance the medical home model of care.

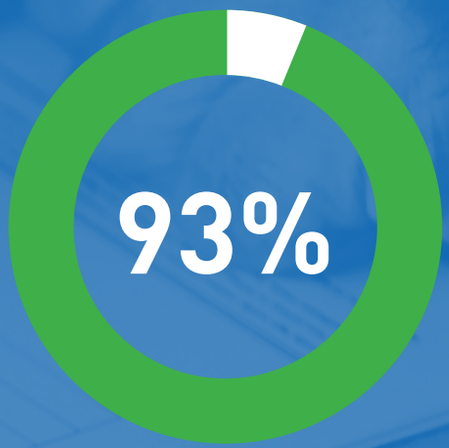
Total Encounters Seen by EWPCN Interdisciplinary Team Members

	2015/16	2016/17	2017/18
Behavioural Health Consultant	5,724	4,727	5,527
Dietitian	3,793	3,037	5,072
Exercise Specialist	867	868	1,044
Pharmacist	3,184	3,093	2,779
Pharmacy Discharge Program	759	884	920
Primary Care Licensed Practical Nurse	8,493	9,698	12,770
Primary Care Registered Nurse	27,635	29,236	28,897
Social Worker	1,030	1,384	1,604
Supportive Therapy	n/a	n/a	372
Why Weight?	108 *referrals*	164 *referrals*	122 *referrals*
After-Hours Clinic	3,178	3,143	3,398
Frail Elderly Outreach Program	164	326	1,023
Lower Leg Assessment Clinic	718	778	891
Low-Risk Maternity Clinic	2,912	2,650	2,483
TOTAL NUMBER OF ENCOUNTERS	**58,457***	**59,824***	**66,780***

**This excludes the Why Weight? referrals.*

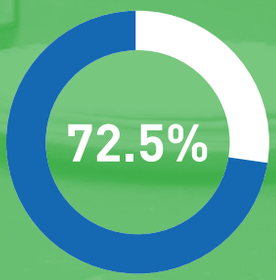
"After my appointments with a behaviour health consultant, I have a more positive attitude, feel happier and have become more assertive, I have used the information provided so I could move forward in my life."

– anonymous client

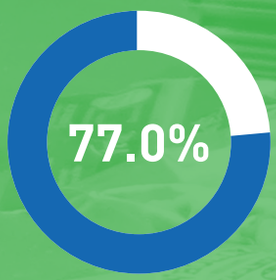


OF OUR PRIMARY CARE TEAM MEMBERS ARE INTEGRATED INTO CLINICS THROUGHOUT THE PRIMARY CARE NETWORK.

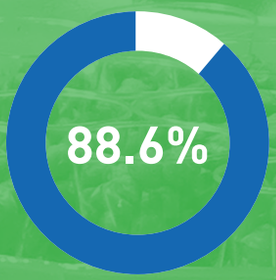
80% OF OUR ELIGIBLE PATIENTS WERE SCREENED ACCORDING TO THE TOWARDS OPTIMIZED PRACTICE GUIDELINES SPECIFICALLY FOR:



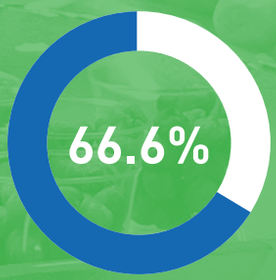
BREAST CANCER



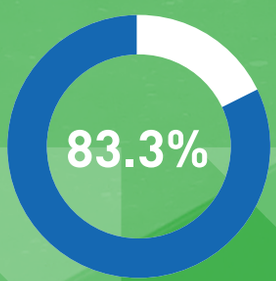
CERVICAL CANCER



CHOLESTEROL



COLORECTAL CANCER



DIABETES

PREVENTION, DETECTION AND TREATMENT

Did You Know?

- 72 physicians in our Primary Care Network are open evenings and some weekends, which avoids unnecessary visits to emergency departments for primary care.
- The After-Hours Clinic also provides an after-hours care option for patients.
- We educated 706 people covering 16 different workshop topics like active living, pre-diabetes nutrition, mindfulness and preparing a personal directive. A new workshop was added this year to help people improve their sleep.
- We supported 920 patients for a safer transition of care after being discharged from hospital to home as part of our Pharmacy Discharge program.

"Very friendly, kind, fast and efficient. I had an ear infection so came to the after-hours clinic. I hope to be pain-free and able to sleep thanks to everyone that works here."

– Nicole

HIGHLIGHTS

Comprehensive Primary Care Nursing

"The Medical Home is essentially a one-stop shop," says Larissa Zuk, RN at Callingwood Crossing Medical Clinic. The role of the comprehensive primary care nurse is integral to accessing expert care and knowledge, especially as it relates to the management of chronic diseases. "Often a physician will refer a patient to me, and I can see them right away," shares Larissa, "for example if a patient is diagnosed with diabetes or their blood sugars are out of control I can work to my full scope of practice and recommend the best treatment plan to the physician." This ensures that patients get the care they need when they need it.

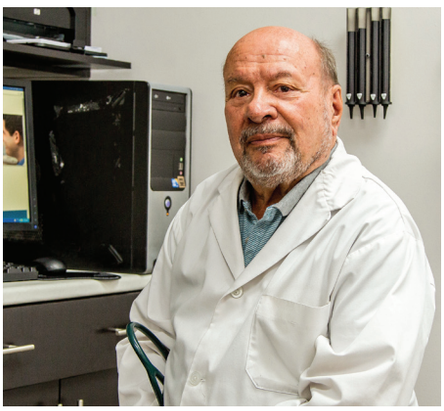
In addition to treatment recommendations, nurses educate patients about an illness or disease.

"I'm so impressed with the nursing care I received at my doctor's office," said one of Larissa's patients. "I received an assessment, treatment and more information about my condition all in one visit. I also registered for a diabetes nutrition workshop and she connected me with the exercise specialist at the Primary Care Network, but the best part is that Larissa follows up with me regularly to be sure I'm still on track."

"I appreciate being able to help patients manage their disease and reduce the stress of a new diagnosis. By providing team-based care, we can really help our patients connect with a dietitian and exercise specialist or register them for a diabetes nutrition workshop," adds Larissa.

"It's a radical enhancement to patient care. It enables us to have a team approach to tap into resources we didn't normally have access to in the past."

- Dr. Romano,
EWPCN Member Physician



ELDERLY PATIENTS WHO BENEFITED FROM THE FRAIL ELDERLY OUTREACH PROGRAM:

1,023

41,667

PATIENTS WERE EDUCATED, TREATED AND CARED FOR BY A PRIMARY CARE NURSE. THE MAJORITY OF THE CARE IS FOR PATIENTS WITH CHRONIC DISEASE.

Frail Elderly Outreach Program

Through our Frail Elderly Outreach program, the medical home is virtual and comes to you.

"What we're most proud of is that through this health service, patients can live safely and independently in their own home longer because they have the continuity of care," states Brenda Lamoureux, Pharmacist for the Frail Elderly Outreach Program.

This innovative program was born out of necessity to help homebound patients with a variety of supports. While many supports are available in the community this program is unique through its' link to the medical home.

"The program fills the gap for these vulnerable patients, by providing care between regular visits to their family doctor," adds Brenda, "by having a nurse practitioner able to provide primary care in the home we can often prevent patients from having to go to the emergency department or require a higher level of care."

It is the two-way communication and collaborative work with the family physician that makes this program successful.

The Frail Elderly Outreach Program has grown from one nurse practitioner and a pharmacist, to include:

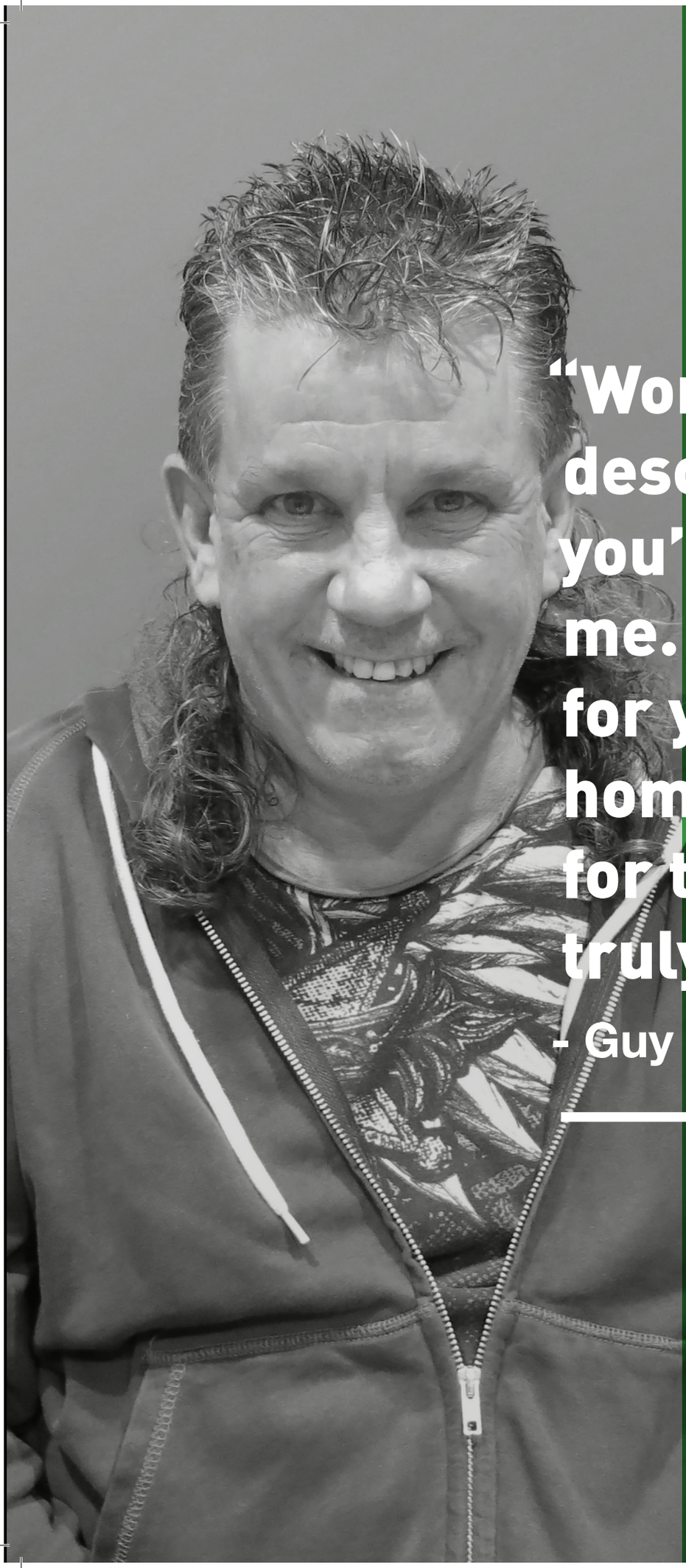
- a pharmacy technician to manage the coordination of appointments and medication.
- an occupational therapist and occupational therapy assistant to keep patients moving, help them maintain the skills needed for daily living and reduce the risk of falls.
- a geriatric nurse to help patients, and their families, cope with certain medical conditions that develop later in life.
- the team also has the support of the EWPCN multidisciplinary team; like behaviour health consultants and social workers for consultation, as it works to integrate and align with other community-based supports such as home care.

"It was so helpful to have the nurse practitioner and Frail Elderly team go out to my 85-year-old patient's home."

- Dr. Wendy Dawson,
EWPCN Medical Director and Member Physician

This team-based approach is based on the individual needs of the patient and is customized so that we can give them the continuity of care they need in the community.

"The program provided valuable insights about my patient's living situation," adds Dr. Dawson, "and the thorough team-based assessment and practical recommendations helped me follow-up and support the family," concludes Dr. Dawson.



“Words can’t describe how you’ve helped me. If it weren’t for you, I’d be homeless — and for this, I am truly thankful!”

- Guy G.

1,003

PATIENTS ACCESS ESSENTIAL SUPPORT FROM SOCIAL WORKERS WHICH IMPROVED THEIR HEALTH AND WELL-BEING.

Social Workers as System Navigators

The collaborative work of our social workers, within the medical home, is critical to addressing the complex issues affecting the health and well-being of over 1,000 patients this past year.

Our social workers help patients navigate the health system or access essential community resources to improve their quality of life.

Here's one example of how our social workers helped a patient beat alcoholism and escape homelessness, just as result of finding a family doctor and scheduling a routine check-up.

For most of his life, Guy would go to the walk-in clinic when he needed medical treatment. His sister urged him to get a regular family doctor through the Edmonton West Primary Care Network. At the time, he never would have realized how this decision would have a tremendous impact over the next few years of his life.

His physician recalls when Guy first came to see him. Guy was jaundiced, weighed only 85 pounds, and his liver had suffered years of abuse through alcoholism. It was imperative he turn his life around, so his doctor referred him to an addictions program where he could learn important life coping skills.

This compassionate approach to Guy's health led him to take control of his addiction through the programs made available to him. "I'm thankful for my family doctor. She's been there for me, and I can tell she cares," states Guy. However, this isn't where the help from his family doctor stopped.

Guy found himself in need again later that year after being struck by a truck while crossing the street. Not only did the accident leave him in chronic pain, but he also lost his job making it nearly impossible to afford the surgeries and medications he required.

His physician was able to step in again and referred Guy to Shannon, one of our social workers. Shannon was able to assist him by collaborating with community resources.

"I was able to find Guy premium-free medical coverage," Shannon happily reports, which directly alleviated Guy's issues in paying for medications.

"I was able to find Guy premium-free medical coverage," Shannon happily reports, which directly alleviated Guy's issues in paying for medications.

With his income limitations, inability to qualify for income support, and difficulty coming up with the funds for a damage deposit, Shannon innovatively found funding to prevent him from becoming homeless.

Guy's decision to attach to a family physician, who is a member of the EWPCN, was fundamental to his health and well-being. Through this relationship he was able to beat his addiction to alcohol, pay for medications and find affordable housing. This demonstrates how a medical home can improve and help the members of this community.

Lower Leg Assessment Clinic

The Edmonton West Primary Care Network's Lower Leg Assessment Clinic is part of the medical home as it strives to prevent disease, illness and injury.

By establishing patient-specific treatment plans and screening for disease, our Lower Leg Assessment Clinic prevents wounds and reduces the risk of further deterioration of tissues to ensure our patients can live active lives.

The Lower Leg Assessment Clinic takes a comprehensive approach to team based care supporting the family physician with specialized knowledge and training in wound care and lower leg assessment.

Whether it is getting clients to wear compression stockings consistently, or educating them on ways to improve their health, the Lower Leg Assessment staff are an important part of the medical home.

"We focus on the legs but we look at the whole person."

- Bridget
Registered Nurse

673

PATIENTS WERE EDUCATED, ASSESSED AND TREATED THROUGH THE LOWER LEG ASSESSMENT CLINIC.

"I am so grateful for the knowledgeable care I received at the Lower Leg Assessment Clinic."

- Neville M.

284 new moms received maternity care at the Low-Risk Maternity Clinic.

"Coming here has alleviated a lot of my stress. I feel as though I'm in good hands. Everyone has been kind and supportive"

– first time mom

CONCLUSION

It's clear, that through our family physicians and their medical home patients can get reliable health care they can trust supported by the EWPCN programs and services.

And the Edmonton West Primary Care Network's family physicians and interdisciplinary team members are leaders are leaders in providing the best primary care to our community.

We are proud of the care and support we give to patients each day.

FINANCIALS

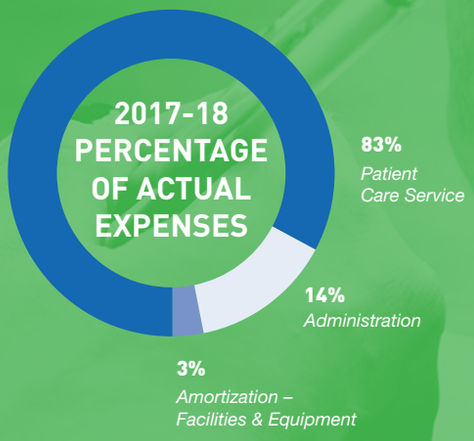
Solid Stewardship

In 2017-18 Edmonton West Primary Care Network delivered programs and services as set out in the business plan agreement with Alberta Health.

Evidence shows that a fully implemented medical home can result in potential savings to the health care system of $300,000 for an average physician panel. For the EWPCN that translates into potential cost savings of over $50 million.

IN 2017-18, THE OVERALL BUDGET WAS JUST OVER

$10M



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