Primary Care Network
EDMONTON WEST

Business Plan Summary

EWPCN 2021-24

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2020-21

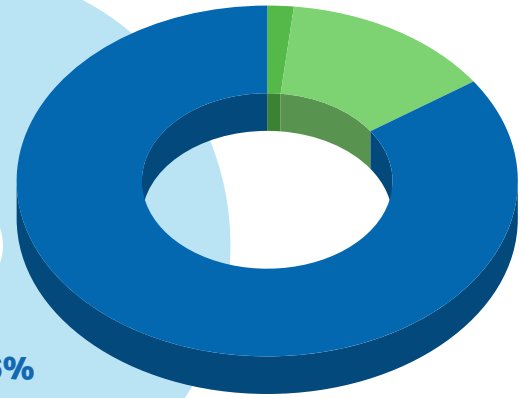
A YEAR IN REVIEW

Primary Care Network
EDMONTON WEST

SOLID STEWARDSHIP

In 2020-21, the Edmonton West Primary Care Network delivered programs and services as set out in the business plan agreement with Alberta Health.

THE OVERALL BUDGET WAS
$11.9M



- PATIENT CARE: 84.6%
- ADMINISTRATION: 13.7%
- AMORTIZATION: 1.7%

HIGH QUALITY PATIENT CARE

182,000 Patients are cared for by 182 family physicians and over 100 at the Edmonton West Primary Care Network

37,251* visits with primary care nurses in 39 clinics

6,737 patients cared for by behavioral health consultants

2,957 patients received nutrition counselling and education from dietitians

1,141 patients helped by social workers

1,087 patients were educated, assessed, and treated at the Lower Leg Assessment Clinic

1,140 patients were seen by a psychiatrist and 440 people accessed Supported Therapy

2,555 patients participated in fitness consultations and classes with an exercise specialist

1,662 patients received medication support from pharmacy staff

248 mothers received maternity care at the Low-Risk Maternity Clinic

3,057** patients living with complex medical conditions received support through the Complex Care Transition Program

*Nursing encounter numbers for 2020/21 were impacted by COVID-19 and compliance with submitting encounters to the EWPCN. A new electronic encounter capture process has been implemented for the 2021/22 fiscal year.

**Because the Frail Elderly program transitioned into CCTP during the 2020/21 fiscal year, the CCTP numbers include the Frail Elderly program and the pharmacy discharge program.

Contents

Introduction

The Edmonton West PCN's (EWPCN) 2021-24 business plan renewal (BPR) builds on the successes of the previous business plan while responding to the emerging needs of patients and the current environment in which the PCN operates.

The EWPCN believes the best primary care can be achieved through the advancement of the patient's medical home within a vibrant medical neighbourhood as described by the College of Family Physicians of Canada. This BPR seeks to partner with physician members, Alberta Health Services and community agencies to ensure a robust medical home integrated within a well-organized medical neighbourhood for all our patients.

The BPR contains three priority initiatives that describe how the EWPCN will enable local solutions to local problems and opportunities within the medical home as well as how the EWPCN will contribute to the Edmonton Zone PCN Service Plan.

1. **Enhancing team-based care through the physician-nurse dyad**

2. **Building competency and capacity within the patient's medical home**

3. **Medical neighbourhood**

Evidence shows that teams in a high functioning patient's medical home exhibit higher levels of satisfaction, experience less burnout and achieve higher quality of care. We consistently hear from our physicians that the greatest contribution the PCN makes to their practice is the team and nurses remain our biggest staffing complement.

We want to put the physician-nurse dyad at the centre of the medical home with the patient to facilitate comprehensive team-based care that breaks down silos and is customized around the individual needs of the patient. This will require optimization of the primary care nursing role as well as further investments in nursing resources for clinics. The EWPCN is committed to evolving high-functioning team-based care to ensure Albertan's have access to the right services provided by the right individual in the medical home.

The EWPCN is well known for its innovative programs and services, such as the Lower Leg Assessment Clinic, which augment team-based care with specialty primary care services. These services are maintained in this business plan with a vision of leveraging the knowledge and experience of these teams to build the competence and capacity of the EWPCN physicians and nurses working directly in the patient's medical home. This will allow the physician-nurse dyad to better meet the needs of patients in their medical home reducing the need for referrals to specialist care. We are also building upon our previous successes to offer a Complex Care Transition Program (CCTP) modeled after our Frail Elderly Outreach Program, which is being enhanced with the introduction of the CCTP.

The EWPCN recognizes that an important element of the patient's medical home is continuous quality improvement. In addition to funding interdisciplinary staff, the EWPCN will invest in resources and supports to enable continuous quality improvement of the patient's medical home.

Finally, the EWPCN is committed to partnering to find integrated solutions to system-level problems through the medical neighbourhood. We know some issues cannot be addressed within the medical home and require coordination and integration within the medical neighbourhood by working with our partners. By doing so we can address root causes of problems, avoid duplication, and build a strong primary health care system.

The EWPCN is forecast to increase its patient panel by approximately 0.5% per year from about 187,000 enrollees forecasted for April 2021 to 189,000 enrollees by March 2024. This growth is consistent with historical trends for the EWPCN. Assuming that the per capita rate of $62 per enrollee, the EWPCN forecasts about $37 million in per capita funding over the three-year BPR.

Evaluation of the EWPCN is focused on three different levels. The first area of focus is on the quality of the EWPCN programs and services ensuring that we provide good value for the use of our per capita funding. Second, the EWPCN seeks to identify and measure metrics related to the overall impact the EWPCN has on the healthcare system through the development of logic models. Finally, the EWPCN promotes and supports physician clinic level evaluation of quality and performance, consistent with the patient's medical home.

EWPCN Strategic Plan

Our Vision

is to provide the best primary care to our community.

Our Mission

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

Our Values

- Integrity
- Respect
- Compassion
- Being Patient-Centered

Our Objectives

We support the following provincial Primary Care Network (PCN) objectives established by Alberta Health:

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 partner with health services and other social services across the continuum of care.

3. Health Needs of the Community and Population

Plan services delivery on high quality assessments of the community's needs through community engagement and assessment of appropriate evidence.

4. Patient's Medical Home

Implement patient's medical home to ensure Albertans have access to the right services through the establishment of interdisciplinary teams that provide comprehensive primary care.

Who We Are

We are made up of more than 180 dedicated family physicians and 100 knowledgeable health professionals who strive to provide the best primary care for patients in the west and southwest regions of Edmonton.

Strategic Priorities

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:

01

Being leaders in facilitating attachment to a family physician for unattached patients.

02

Building capacity for patients to reliably access appropriate 24/7 primary care through their medical home.

03

Maximizing the capacity of primary care to respond to the needs of our patients by building and leveraging the skills of our family physicians.

04

Decreasing the burden of mental illness for our patients by increasing the capacity of the medical home to support mental health.

05

Improving the quality of patient care by supporting the adoption of current and effective clinical practices.

06

Reducing identified barriers to care within our community for vulnerable populations based on demographic data (populations to be determined).

07

Partnering for zone-level solutions for safer and efficient transitions of care.

08

Partnering for zone-level solutions to improve access to specialist care.

Patient's Medical Home

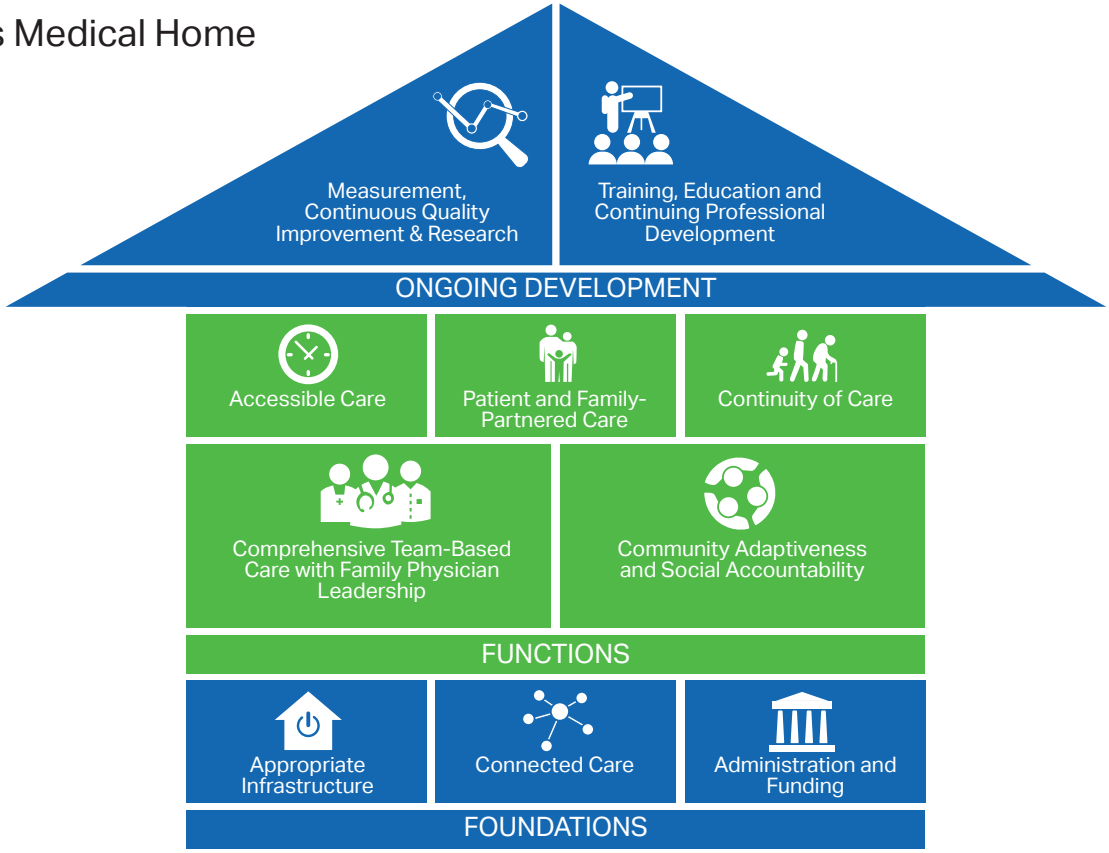
The EWPCN believes that the best primary care is a robust medical home for all patients in our community.

We will support our family physicians in building a medical home for our patients.

In 2011, the College of Family Physicians of Canada (CFPC) defined their vision of the Patient's Medical Home (PMH) as "every family practice across Canada offering medical care that Canadians want—seamless care that is centered on individual patients' needs within their community, throughout every stage of life, and integrated with other health services."[1] In March 2019, the CFPC updated the pillars of the PMH as follows[2]:

Figure 1.

The Patient's Medical Home



[1] https://patientsmedicalhome.ca/

[2] College of Family Physicians of Canada. Summary of a New Vision for Canada: Family Practice—The Patient's Medical Home 2019. Mississauga, ON: College of Family Physicians of Canada; 2019.

Priority Initiative #1

Enhancing team-based care through the physician-nurse dyad

We intend to put the physician-nurse dyad at the centre of team-based care to facilitate comprehensive care that breaks down silos and is customized around the individual needs of the patient. We will do this by building our complement of nursing staff—registered nurses, licensed practical nurses, and nurse practitioners—incrementally over the three-years to achieve a goal of 0.2 FTE of nursing staff per 1000 paneled patients (according to Alberta Health four-cut methodology). We are also implementing a Nurse Role Review aimed at establishing a consistent framework for primary care nursing competency development ensuring nurses contribute to optimal team functioning and effectiveness in the patient's medical home (PMH).

Elements

Primary Care Nurses

Primary Care Nurses will work to their full scope of practice within the medical home. Our vision of the scope of the primary health care nurses is: patient care, organizer, quality controller and improvement agent, problem solver, educator, and agent of connectivity. The primary care nurses support safe transitions of care into and out of the medical home and are knowledgeable about community supports to ensure care coordination, linking patients and their families to appropriate programs and services.

Our primary care nurses work with family physicians to help their patients receive wholistic primary health care, chronic disease management, and health promotion/education.

Our Primary Care Nurses:

- teach patients self-management skills and provide follow-up support.
- assist with screening, provide health promotion and disease prevention.
- provide general nursing care, chronic disease management (diabetes, chronic obstructive pulmonary disease, hypertension, asthma, cardiac disease, and chronic pain) and relevant patient education to prevent and manage clinical conditions as required within their scope of practice.
- provide diabetes education, insulin initiation and ongoing adjustment management.
- educate patients regarding medications, lab results, diet, exercise, healthy-lifestyle management, smoking, etc.
- assist with coordination of patient care and follow-up to help patients navigate the health system.
- dentify needs and set priorities in collaboration with the clinic team.
- make follow-up calls (i.e. – abnormal lab results, orders).
- injections, ear syringing, dressing changes, clinical procedures, pap smears, ECGs and other patient care activities related to the clinical management of patients with proper documentation.
- assist with complex care plans.
- administer St. Louis University Mental Status (SLUMS) examination.

Infrastructure Payments

Our experience shows us that embedding nursing staff directly in the patient's medical home achieves favorable outcomes in terms of access, continuity of care, and team effectiveness, as reported by our physicians and nurses.

By working in the clinic, nurses are able to build relational continuity with patients and can assist in a shared care approach with physicians on complex patients. The majority of our nursing staff are decentralized to the physician's office. There are overhead costs associated with providing infrastructure for the EWPCN staff in clinic such as space, equipment, supplies, EMR licensing, etc. Infrastructure payments are meant to offset some of these costs.

The Infrastructure Support element is funding allocated to physicians to offset the cost of having PCN staff housed in physician clinics (e.g. overhead costs including rent for space, IT cost).

Infrastructure Support in the 2021-2024 Business Plan will be $550 per month per 0.23 FTE of decentralized staffing.

Priority Initiative #2

Building the competence and capacity of the medical home

In their vision of team-based care in the patient's medical home the Canadian College of Family Physicians states, "the combined skills and expertise of the interprofessional PMH team ensures patients can easily access a variety of services, and that they are given relationship-driven, compassionate care.[3]" The EWPCN has adopted a team-based approach to care that allows us to provide comprehensive care that is coordinated, collaborative and efficient.

While we have embedded some non-nursing staff in the physician's office, the model has largely been referral based. We want to add a consultation and capacity building component to leverage the expertise of the team to build competence and capacity of the physician-nurse dyad. By building the competence and capacity of the dyad, the needs of patients can be better served within the medical home.

Our goals for this priority initiative are to break down siloes in team-based care and to leverage the expertise of our interdisciplinary team to educate and consult with our physician-nurse dyad.

Elements Of Building Capacity of the Medical Home

Interdisciplinary Team

Key to the success of the EWPCN 2021-24 Busines Plan is the contribution and excellent care provided by the Interdisciplinary Team. The EWPCN provides a range of interdisciplinary team (IDT) members to support comprehensive team-based care and capacity building in the medical home:

- Dietitian
- Behavioural Health Consultant
- Exercise Specialist
- Pharmacist
- Social Worker
- Psychiatry

See Appendix A for a brief scope of practice description for each discipline.

The IDT supports patient care for complex patients working to their full scope of practice. The IDT also builds the competence and capacity of the physician nurse dyad through consultation and treatment planning with the physician and/or nurse, by breaking down siloes and promoting high functioning team-based care.

Clinical Excellence Team

The third element of the EWPCN 2021-24 Business Plan supports the ninth pillar of the patient's medical home through measurement, continuous quality improvement, and research. [4] The EWPCN identified this as an area where we have expertise and can offer support to physicians to enable measurement and continuous quality improvement.

The EWPCN has established a Clinical Excellence team to work collaboratively with staff, physicians, and other clinic staff to initiate and participate in quality improvement initiatives.

Medical Home Enhancement Funding

Another key element of the EWPCN 2021-24 Business Plan supports physician leadership in continuous quality improvement (CQI) activities through some financial support. The EWPCN Medical Home Enhancement Fund is intended to assist physicians in building capacity and establishing the structures and processes for continuous quality improvement in their clinics. As quality improvement practices become embedded in the clinic culture, the time investment of physicians is expected to decrease and consequently, the Medical Home Enhancement Funding will be gradually phased out over the three-year business plan.

- 2021-22 Medical Home Enhancement Fund: $2000 semi-annually
- 2022-23 Medical Home Enhancement Fund: $1000 semi-annually
- 2023-24 Medical Home Enhancement Fund: $500 semi-annually

[3] Canadian College of Family Physician's Patient's Medical Home website. https://patientsmedicalhovme.ca/vision/

Accessed October 21, 2020.

[4] ibid

Lower Leg Assessment Clinic

The Lower Leg Assessment Clinic staff works with the family doctor and nurse to develop a treatment plan for patients with lower leg edema and wounds. (Please note we follow all regional guidelines for treatment and will forward comprehensive reports with recommendations for the patient's plan of care.) The clinic provides:

- educated/certified RNs in wound/compression therapy and comprehensive lower-leg assessments.
- ABI testing for patients to rule out PAD, claudication, as well as screening for high- risk patients.
- compression therapy consults and treatment. CVI class 1-4, compression wrapping and/or compression stocking recommendations. AADL authorizations completed for patients who qualify.
- wound management consultations and treatment (Stage 1-3 wounds, arterial/venous ulcers).
- sharp debridement as needed, except for gangrene.
- treatment protocols and referrals to homecare, if necessary.

Low Risk Maternity Clinic

The EWPCN Low Risk Maternity Clinic offers pre- and postnatal care to low-risk maternity patients. The care team is made up of experienced family doctors who specialize in obstetrics and deliver babies at the Misericordia Community Hospital.

Complex Care Transition Program

The Complex Care Transition Program (CCTP) provides patient-centered, interdisciplinary care and support the seamless transition of patients living with medical complexity from acute and/or specialty care back to their Medical Home.

BRiC (Building Resilience in Caregivers)

The BRiC program supports caregivers and people living with dementia living independently in our community. Through the ten-week program caregivers have an opportunity to connect with other caregivers and learn about how to maintain their own health and wellbeing with a variety of team-based health care resources (occupational therapy, behavioural health consultants, exercise specialists, registered nurses, pharmacists, social workers and dietitians).

Supported Therapy Services

Supported Therapy Services provide support for those patients who require more intense counseling but face a financial barrier to accessing care. This service is provided by contract with several community providers. Behavioural Health Consultants triage patients and refer them for Supported Therapy, as required.

Staff & Physician Education

In addition to providing programs and services that support comprehensive care in the patient's medical home, the EWPCN will support staff and physicians to engage in continuing professional development. The tenth pillar of the patient's medical home identifies the importance of training, education, and continuing professional development for the ongoing development of the PMH.[5]

The EWPCN provides education events for staff and physicians aligned with advancing the mission, vision, and values of the EWPCN and the advancement of the Zone PCN Service Plan Priority Initiatives.

Pediatric Mental Health

The EWPCN has set as a goal to expand our scope of mental health services to better support pediatric mental health in the patient's medical home. This will require a period of discovery and design as we build our expertise in this area. As we look for opportunities to provide local solutions for this patient population, we will intersect with the Edmonton Zone Addictions and Mental Health Working Group to ensure integrated solutions, where appropriate.

Chronic Pain

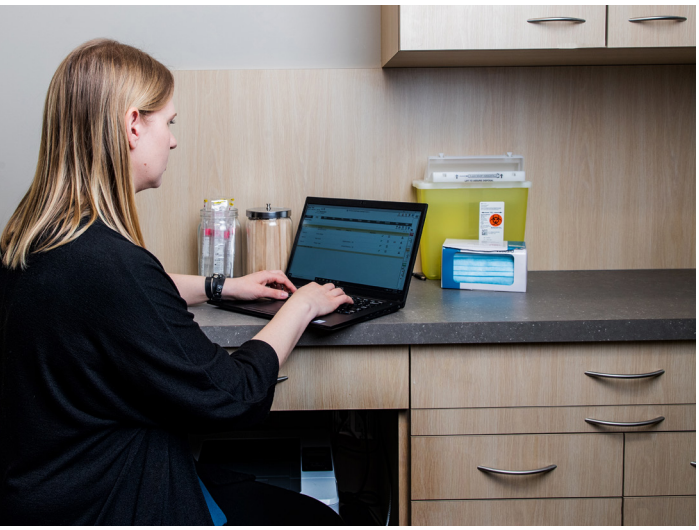
The EWPCN has set a goal to expand our scope of services to better manage chronic pain in the patient's medical home. This will require a period of discovery and design as we build our expertise in this area. As we look for opportunities to provide local solutions for this patient population, we will intersect with the Edmonton Zone Addictions and Mental Health Working Group to ensure integrated solutions, where appropriate.

Patient Education

In addition to providing one-on-one patient care, our teams provide a variety of group education classes in a variety of health topics including mental health and wellness, active living, healthy eating, and chronic disease management. Patients can self-register for these education classes. Please refer your patients to the EWPCN website for the most up-to-date schedule.

[5]College of Family Physicians of Canada. Summary of a New Vision for Canada: Family Practice—The Patient's Medical Home 2019. Mississauga, ON: College of Family Physicians of Canada; 2019.

Priority Initiative #3



Medical Neighbourhood

The medical neighbourhood is defined by the Primary Care Collaborative as a "clinical-community partnership that includes the medical and social supports necessary to enhance health, with the patient centred medical home serving as the "hub" and coordinator of health care delivery."[6] The medical neighbourhood supports patient care activity (including self-care) that occurs largely outside the family physician clinic, and involves a wide range of professional supports and services, community agencies, and personal resources that contribute to individual well-being. The EWPCN Medical Neighbourhood will be fostered through:

Local Solutions to Local Problems

- Individual PCNs provide specific, local medical home services to their defined patient population and geography.

Common Solutions for Common Problems

- Edmonton Zone Pan-PCN provides a structure for inter-PCN and a focused PCN-AHS cooperation and coordination to serve a larger population of patients and communities within the medical neighbourhood.

Integrated Solutions for System Level Problems

- Edmonton Zone Service Plan provides a structure for extensive PCN-AHS collaboration related to system level integration and population health improvements across the medical neighbourhood.

This medical neighbourhood priority initiative is shared by all EZ PCNs and is reproduced in all EZ PCN business plans.

The Edmonton Zone Service Plan is directed at system level integration to support system level improvements, population level health services delivery, and increased integration and reduced duplication of programming and administration.

The Edmonton Zone Service Plan is developed and governed by the EZ PCN Committee which includes all eight PCN physician leads and AHS Edmonton Zone Senior Leadership. PCN Executive Directors, AMA, AHS provincial Primary Health Care and Alberta Health attend as non-voting members.

The Edmonton Zone service plan outlines the following three priority areas and 8 deliverables:

Addictions and Mental Health (A&MH)

- Establishing and supporting the use of a common tool to reliably assess a patient's needs and align them with an appropriate service.
- Adopting a sharing care model with a patient's medical home that facilitates better integration and coordination of specialty care.
- Developing coordinated and integrated care pathways with partners, as well as resources to improve physician knowledge and competencies, in response to the opioid crisis.

Transitions of Care (TOC)

- Attachment to a medical home with specific focus on attachment of unattached patients on discharge.
- Discharge planning process with a focus on hospital to home transitions.

Specialty Access & Linkages (SAL)

- Innovative and timely access to specialty advice and care.
- Establishing communication pathways between primary care and specialty access.
- Create consistent clinical pathways for specialty access.

[6]Primary Care Collaborative website accessed October 20, 2020: www.pcpcc.org/content/medical-neighborhood.

Elements of the Medical Neighbourhood

Pan-PCN Supports

The EWPCN contributes funding toward Pan-PCN to support the development and implementation of collaborative initiatives within the Edmonton Zone.

Transitions of Care

We support attachment of unattached patients within the Edmonton Zone. We do this through the Alberta-Find-a- Doctor (AFAD) website for the general public. Patient Attachment Assistants are also available to assist complex patients that are having difficulty attaching to a family physician.

Specialty Access and Linkages Support

ConnectMD

ConnectMD is a PCN program that offers family physicians in the Edmonton, North and Central zones access to over 30 local specialty groups for routine patient advice over the phone.

A family physician wanting to receive specialist advice calls the ConnectMD line and speaks to a trained coordinator who will collect pertinent information about the request. The coordinator will then connect the specialist with the family physician for a phone consultation.

To use Connect MD, call or text (toll free): 1-844-633-2263

Addictions and Mental Health

Several initiatives are underway to improve the integration, coordination and comprehensiveness of addictions and mental health care. Goals include supporting competency development in the patient's medical home and the implementation of tools and protocols.

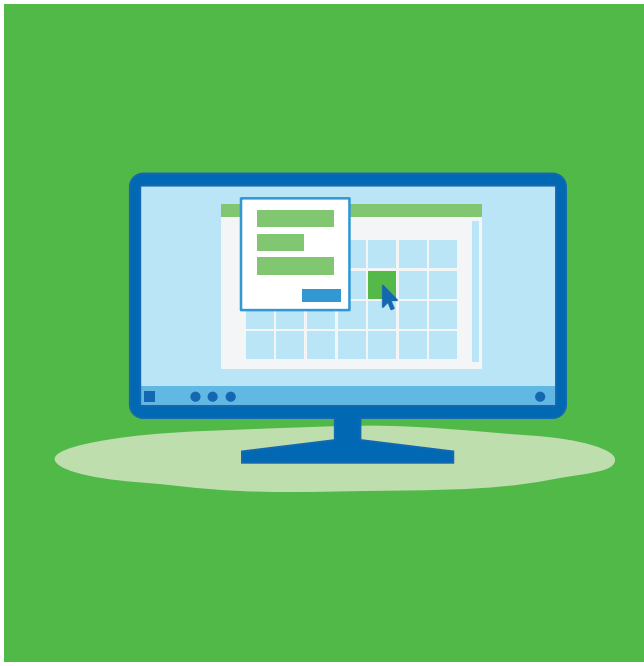
Alberta Health Services Opioid Dependency Satellite Clinic

Since August 2018, EWPCN is home to Alberta Health Services' Opioid Dependency program (OPD). Patient- centered treatment is provided by an OPD physician and Outreach Nurse. Patients are stabilized on methadone or suboxone, under close medical supervision and evaluation in response to medication. The AHS Opioid Dependency program may also include; ongoing support and monitoring, health, safety and risk reduction teaching and management, attachment to a family physician and links to community resources.

Anyone can access this program by calling 780-405-8193.

Evaluation

The EWPCN will take the following approach to evaluate and improve programs and services to achieve the outcomes outlined in the 2021-24 business plan:



- Program Evaluation: ensure the programs and services of the EWPCN are high quality.
- System-level Evaluation: measure the impact that the EWPCN programs and services have at the system level.
- Quality Improvement: The EWPCN Quality Team will action outcomes focused quality improvement initiatives to increase quality (dimensions of quality may include access, efficiency, capacity, experience, and cost savings) across EWPCN programs and at the member clinic level.
- To enable this work, the EWPCN partners with others to optimize data collection and evaluation.

Information Management Agreement

To better understand the impact of EWPCN services on patient care, the organization requires physician members to sign off on an Information Management Agreement (IMA). The IMA allows the EWPCN and physician members to access system level data available through external partners. The IMA is an agreement between the EWPCN and the physician member that outlines how patient information is shared, stored and protected, ensures we are meeting current data sharing standards and names the EWPCN Medical Director as the Master Custodian.

Continuing Competency Department of CPSA

The EWPCN partners with the Continuing Competency Department of the College of Physicians and Surgeons (CPSA) of Alberta to enhance the data available to physicians in the MD Snapshot. MD Snapshot is produced by the Continuing Competency department of the College to assist physicians with quality improvement in their practice.

The goal of this partnership for the EWPCN is to provide meaningful, timely and actionable data for our physicians. Aggregate, anonymous data about EWPCN physicians as a group is compiled and presented in your MD Snapshot for comparison purposes. This will help identify trends in physician prescribing practices.

Health Quality Council of Alberta

The Health Quality Council of Alberta (HQCA) is a provincial agency that brings an objective perspective to Alberta's health system, pursuing opportunities to improve person-centred care, patient safety and health service quality for Albertans. The HQCA gathers and analyzes information, monitors the healthcare system, and collaborates with stakeholders to translate that knowledge into practical improvements.

One initiative of the HQCA is the production of Primary Healthcare Panel Reports. Since 2011, the HQCA has been providing Primary Healthcare Panel Reports upon request to family physicians across the province. This free resource is an invaluable tool to support and inform program planning, panel management, quality improvement, and policy development at the various levels of the primary healthcare system. Physicians are encouraged to access their Primary Healthcare Panel Reports and share their report with the Clinical Excellence Team. The Clinical Excellence Team can assist with accessing and reviewing Primary Healthcare Panel Reports for physician members. These reports can also assist with Medical Home Enhancement action planning.

Appendix A

Brief scope of practice descriptions for Interdisciplinary Team Members

Dietitian

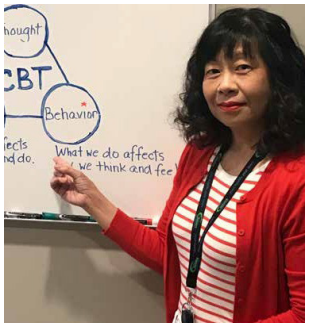
An integral part of your health and wellness is dependent on nutrition.

Our registered dietitians are important team members within the patient's medical home. As nutrition experts they are your trusted source for advice and based on Canada's Food Guide, our registered dietitians help you to gain the nutrition knowledge, skill and confidence needed to improve your health.

Our registered dietitians can help with:

- managing chronic diseases like diabetes or high cholesterol.
- nutrition for every age: children to seniors.
- stomach issues (Irritable Bowel Syndrome and Crohn's disease).
- weight concerns.
- health eating on a budget.
- tips for picky eaters.
- ideas to balance vegetarian or vegan diets.
- solutions for eating with food sensitivities or allergies.

Behavioural Health Consultants (BHCs)



Behavioral Health Consultants (BHCs) help build habits, behaviors to manage stress, worry, or emotional concerns about physical or other life problems are interfering with a person's daily life or overall health. BHCs work with physicians to evaluate the mind-body- behavior connection and provide brief, solution-focused interventions and help determine a course of action that will work best for patients.

Our BHCs see patients for health concerns such as:

- sleep issues.
- chronic pain and illness.
- headaches.
- depression.
- anxiety.
- anger, grief and stress.
- weight concerns.
- relationship parenting issues.
- substance use and addictions.
- psychiatry consult.
- supported therapy services.

Pharmacists

Our pharmacy team supports the patient's medical home by working with the physician-nurse dyad and other health care providers to help patients better understand their medication. This is especially important for patients taking multiple medications or managing complex health conditions.

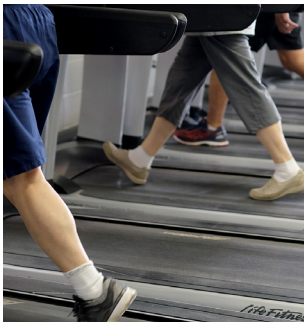
Our pharmacists can provide a variety of services that will assist with the patient's health and well-being, including:

- answering medication questions and ensuring it is being used properly.
- reducing the risk for adverse drug events and interactions.
- hospital discharge program to ensure the safe transition from hospital to home.
- quit smoking and staying a non-smoker.

Our pharmacy team provides expert advice for:

- chronic pain management.
- chronic diseases like diabetes, high blood pressure, asthma, arthritis and others.

Exercise Specialists



Our exercise specialists promote active living and exercise to help maintain a healthy lifestyle. Our exercise specialists assist patients with physical activity challenges and help them develop a personalized exercise prescription.

Active living and exercise can also help prevent and manage chronic diseases including arthritis, osteoporosis, diabetes, hypertension, chronic pain, fibromyalgia, weight issues and more.

The EWPCN provides exercise education in group and individual settings throughout the community by:

- learning how to start moving more and how to stay active with little or no equipment.
- increase patient's confidence with physical activity .
- modifying activity for people with chronic pain and fatigue.
- linking patients with nearby community resources.
- setting goals to increase activity at home, in the community and while travelling.

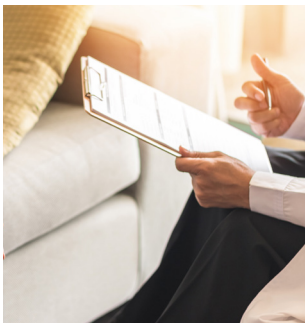
Social Workers

The collaborative work of our social workers within the medical home, help patients navigate the health system or access essential community resources to improve or maintain their health and wellbeing.

Our social workers offer solution-focused interventions and assist with practical matters, such as:

- financial services (income support and debt management, forms).
- medication coverage options.
- links to community resources (seniors services, disability supports, domestic violence, career and employment counselling, caregiver support and legal services).
- guidance on personal directives.

Psychiatrists



The EWPCN psychiatric care provides a patient assessment to assist with diagnostic clarity and treatment recommendations for physicians. They do not provide case management.