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A blurred photograph of a hospital hallway with blue walls and white doors, serving as the background for the right side of the page.

ANNUAL REPORT

FISCAL YEAR 2023

WHAT IS A PCN?

A PCN is not necessarily a bricks-and-mortar building – it is a “network” of family physicians and health care providers working together to provide primary care to patients. A PCN may be composed of one clinic with many physicians and support staff or several physicians in several clinics across a geographic region.

Each network is unique and has the flexibility to develop programs and provide services that meet the specific needs of its patients. This grassroots approach allows – and encourages – the PCN to focus on the needs of the local patient population.

LEDUC BEAUMONT DEVON PRIMARY CARE NETWORK

We are a network of primary care providers supported by a team of healthcare professionals. We work together, and with our patients, to treat and manage their health concerns.

Alberta has 39 PCNs operating in communities and areas across the province.

Over 85 percent (4300+) of all family doctors in the province practice within PCNs along with 1700 allied health care providers.

PROVINCIAL OBJECTIVES

Primary Care Networks across the province provide services that best meet the needs of their patient populations. With this being said, provincial objectives are set for all PCNs.

Accountable & Effective Governance

Establish clear and effective governance roles, structures and processes that support shared accountability and the evolution of primary healthcare delivery.

Strong Partnerships & Transitions of Care

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

Health Needs of the Community and Population

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

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.

PATIENT'S MEDICAL HOME

The Patient's Medical Home, as defined by patients, is the place they feel most comfortable to discuss their personal and family health concerns.

The patient's family physician or nurse practitioner, the most responsible provider of their medical care, works together with a team of health professionals, to coordinate comprehensive healthcare services and ensure continuity of patient care. These professionals can be located in the same physical site as the family physician or linked through different practice sites such as a PCN.

The Patient's Medical Home enables the best possible outcomes for each person, the practice population and the community being served.

ABOUT US

The Leduc Beaumont Devon Primary Care Network provides services for patients in the Cities of Leduc and Beaumont, Town of Devon, and all communities in Leduc County. A group of 57 family physicians and 1 Nurse Practitioner working in 16 locations, along with additional health care professionals (registered nurses and dietitians, an exercise specialist, mental health therapists and behavioural health consultants) work together to improve primary care for our patients.

Primary Care Networks (PCNs) use a collaborative team approach to provide care for patients and to coordinate primary health care services provided by family physicians, Alberta Health Services, and other health care professionals.

PCNs are a way to provide team support for family doctors by bringing teams of health professionals together. PCNs also manage 24-hour patient access to appropriate primary care services.

A PCN is a network of family physicians and health care providers working together to provide primary care to patients. A PCN may be composed of one clinic with many physicians and support staff, or several physicians in several clinics across a geographic region.

Each network is unique and has the flexibility to develop programs and provide services that meet the specific needs of its patients. This grassroots approach allows – and

encourages – the PCN to focus on the needs of the local patient population. Alberta has 39 PCNs operating in communities and areas across the province with over 85 percent (4300+) of all family doctors in the province practicing within those PCNs.

The Leduc Beaumont Devon Primary Care Network began operating on March 1, 2006.

OUR VISION

The Leduc Beaumont Devon Primary Care Network provides services for patients in the Cities Integrated and comprehensive primary health care for a healthier Leduc County and its communities.

OUR CORE VALUES

We will maintain the highest standards of **INTEGRITY** in our behaviour and ethics, by being transparent, honest, and honourable in all our interactions.

We will be **ACCOUNTABLE** to the public and our members and take responsibility of our own actions and decisions.

OUR MISSION

To sustain and enhance health care provision in Leduc and area through coordinated health care delivery and to improve quality of life for the community of patients and physicians.

We will strive for **QUALITY** in our organization by following best practices and challenging ourselves for continuous improvement in our work.

We will demonstrate **RESPECT** in all of our interactions with others.

PRIMARY CARE PROVIDERS

- 57 member physicians
- 1 Nurse Practitioner
- Working in 16 Clinics/Locations
- Supported by 15 Allied Healthcare Providers

WHO WE SERVE

82,776 population catchment area

53,878 paneled patients*

- Leduc
- Beaumont
- Devon
- Calmar
- Thorsby
- Warburg
- Leduc County

PCN TEAM

36 allied healthcare professionals and staff, including:

- Registered Nurses
- Licensed Practical Nurses
- Nurse Practitioner
- Registered Dietitians
- Exercise Specialist
- Behavioural Health Consultants
- Mental Health Therapist
- Social Worker
- Referral Coordinators
- Clinical Administrators
- Administrative Support Staff

*In the most basic definition, paneled patients is the group of patients who consider a physician to be their primary care provider, and that physician agrees.

Part of **YOUR** Medical Home



www.lbdpcn.com



Collaborative care in:

- diabetes management
- tobacco cessation
- weight management
- mental health
- geriatric consultation
- referral coordination
- exercise prescriptions
- health education classes
- after-hours clinics in Leduc & Beaumont
- specialists clinics



MESSAGE FROM THE EXECUTIVE DIRECTOR

2023/24 was a year of engagement, planning and early program changes across primary care. For instance, the release of the MAPS recommendations and subsequent 2-year plan, the allocation of stabilization funding to PCNs and primary care physicians, the introduction of the Panel Management Support Program, the launch of the new funding model for Nurse Practitioners, restructuring of Addictions and Mental Health/AHS, and the ongoing work towards a physician compensation agreement.

The Edmonton Zone PCN Committee was successful in establishing sub-committees/working groups in the areas of Addictions and Mental Health, Building Capacity in Primary Care, Specialty Access and Linkages, and Transitions of Care with the mandate to align objectives to the 3-year Zone Service Plan. In addition, the Zone welcomed a new Director of Operations. Moreover, the Zone communications team is working closely with each PCN to keep stakeholders informed about pertinent activities via a monthly newsletter and a new website.

At the PCN level, LBDPCN continues to face reductions in panel size (and corresponding budget) as physicians leave practice and/or assume more hospital coverage opportunities. The regional population is expanding (over 80,000), yet primary care practitioner capacity is shrinking. The current per capita funded panel is 53,878, whereas the 5-year peak was 60,734.

Our hybrid team-based care approach remains highly successful as more services are offered in physician clinics. Centrally, we have added GLAD programming for osteoarthritis management and restarted the social work program, with demand quickly outpacing capacity. In addition, LPN supports have expanded in several of our medical homes.

Our referral coordination program is essential to linking patients with specialist providers and navigating the nuances of referral systems across the Zone. The team actively facilitated and monitored more than 18,000 referrals last year.

Our specialty linkages clinics for geriatrics, psychiatry and physiatry continue to experience high demand and, consequently, additional appointment days are added as needed. In total, 600 new assessments were completed in these service areas. The new Personal Directive/ Power of Attorney workshop has been incredibly successful and is in high demand.

CII/CPAR adoption remains a key initiative. The LBDPCN has 49% of members live or in progress, with a target of 90% this year as our largest clinic adopts a compliant EMR in April 2024. Furthermore, our QI team continues to work with medical homes, and our central teams are increasing program and system efficiencies.

While the after-hours clinic remains closed, enhanced access continues to be offered in the Thorsby and Warburg communities via the stand-alone NP clinics. Based on patient feedback, the NP program has been incredibly successful, and the panel is now close to 500.

Adopting our new EMR and associated features has enhanced evidence-based care and strengthened patient-centred interactions. In addition, an organization-wide data strategy has been initiated to improve the use of the EMR and subsequent reports.

There is considerable change on the horizon as Alberta Health advances down the path of system reform. I am confident that team-based primary care will remain central to the future model, and we will continue to play a critical role in enhancing patient and provider experiences through collaboration and best practices.

~ Jason Sheehy

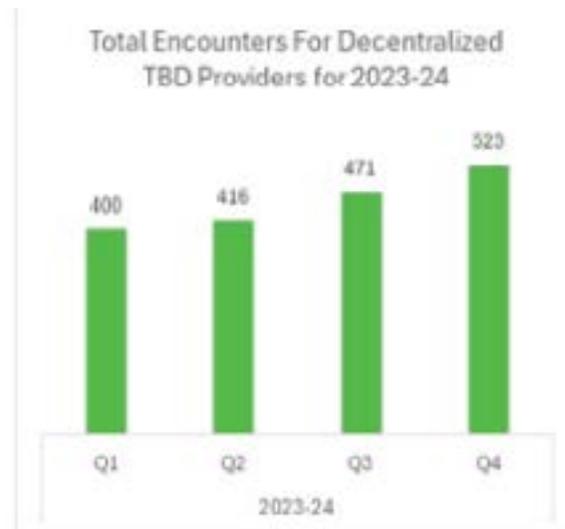
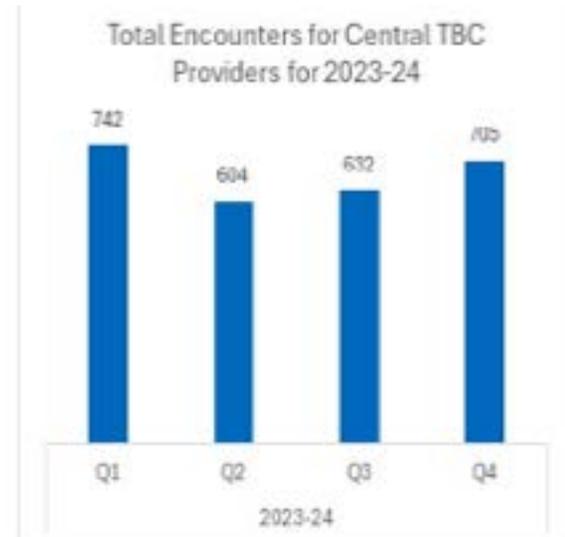
TEAM-BASED CARE PROGRAM

The Team-Based Care Program works with our member physicians to provide support to patients with a variety of concerns. We have healthcare team members working both in our central Leduc office (centralized) and within some of our clinics (decentralized). Registered nurses, registered dietitians, an exercise specialist, behavioural health consultants, and mental health therapists support patients through their health journey.

As of the end of this past fiscal year (March 31, 2023), our Team-Based Care program consisted of:

- Registered Nurses (1.6 FTE)
- Nurse Practitioner (0.2 FTE)
- Licensed Practical Nurse (4.3)
- Registered Dietitians (1.40 FTE)
- Exercise Specialist (0.8 FTE)
- Behavioural Health Consultants (1.7 FTE)
- Mental Health Therapists (1.0 FTE)
- Social Worker (0.6 FTE) *NEW ROLE THIS YEAR

Six health education classes were held last year including Anxiety to Calm, Happiness Basics and Move into Health. The GLAD program for Hip and knee Osteoarthritis was reintroduced into the class line up for the first time since 2019. The public also has access to health education classes via Edmonton Zone Primary Care Networks.



Testimony taken by the 2023 patient experience survey for the team-based care program:

“I really like having the provisions of this office, there is always help when needed.”

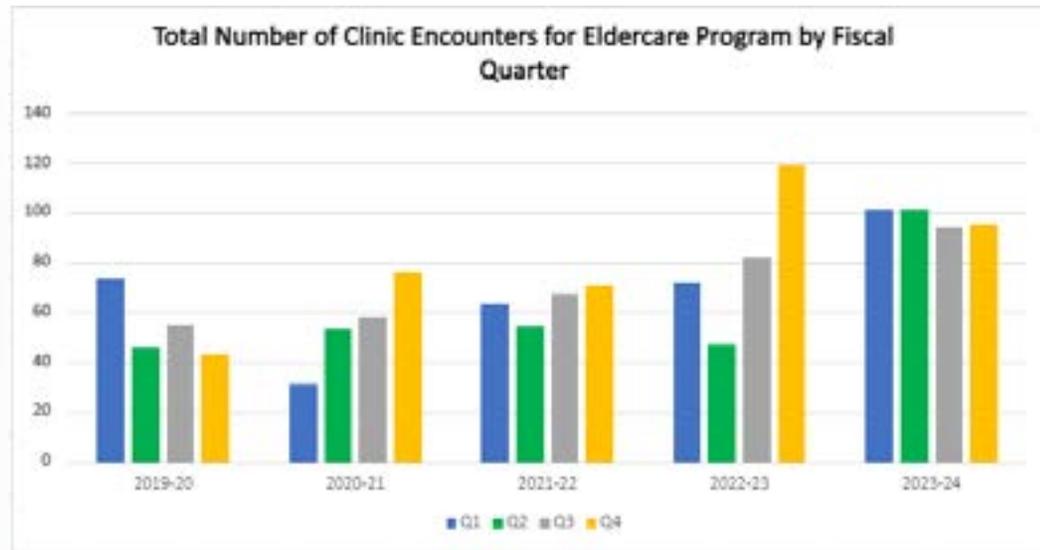
LEDUC ELDERCARE CONSULTATION TEAM

The Leduc Beaumont Devon Primary Care Network provides a specialized geriatric assessment service for seniors who have chronic, complex health issues. Our goal is to ensure seniors living in Leduc, Beaumont, Devon, and Leduc County enjoy optimal health and quality of life while remaining in the community for as long as possible.

During this fiscal year, 200 new referrals were made to the LECT. The LECT offered 55 clinics throughout the fiscal year. 156 new assessments and 235 follow-up visits were conducted (up 71 from 2022-23). In addition to these clinics, the RN also does case management, case conferences, and case reviews.

New Referrals - 200

Total Encounters - 1445



Testimony taken by the 2023/2024 patient and caregiver experience survey for the geriatric clinic:

“We found this clinic very respectful and informative. Keep up the good work!”

SPECIALTY CLINICS

Access to specialists for patients living in suburban and rural communities has always been a challenge. Our PCN aims to partner with various specialty groups to provide patients with local access to specialist consultation services. Through the Leduc Beaumont Devon PCN office, we currently run specialty clinics in geriatrics (see Leduc Eldercare Consultation Team section above for details), psychiatry and musculoskeletal concerns.

The PCN provides local access to specialists to improve continuity of care between primary and secondary care.

Psychiatry

During this reporting period, one visiting psychiatrist saw 203 patients during 48 clinics throughout the fiscal year. The visiting psychiatrist offered most patients in-person appointments this past year but still accommodated virtual visits if that was patient's preference.

Musculoskeletal

The MSK specialist saw 300 patients at 31 clinics at the PCN during the past fiscal year. As the nature of these appointments requires a physical exam, most appointments are in-person; however, a virtual option is available if necessary.

REFERRAL COORDINATION

The LBD PCN Referral Coordinators advocate for the patient and assist the physicians in making sure patients move through the system as seamlessly as possible, with good quality care, from both within and outside the PCN. They develop linkages with various community health resources to deal with patients requiring treatment and referral. The Referral Coordinators develop and manage patient referral programs, confirm appointment details with referring offices as well as initiate, maintain and update the referral database and confidential medical files and records, as indicated.

Referrals Processed - 18,481

Our Referral Coordination team of five coordinators plus a manager, coordinates referrals, appointments and closes the loop between primary care providers and specialists.

NURSE PRACTITIONER-LED CLINICS

Nurse practitioners (NPs) are registered nurses with graduate education and training in advanced clinical practice. After receiving a degree as a Registered Nurse, Nurse Practitioners continue their education, obtain a Graduate degree and receive additional advanced clinical training.

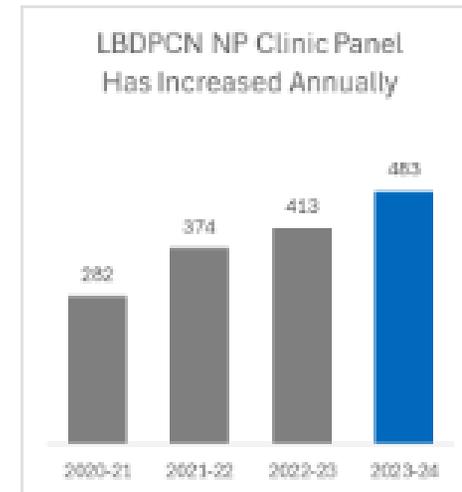
They conduct comprehensive health assessments, diagnose health conditions, and treat and manage acute and chronic illnesses within a holistic model of care. NPs order and interpret screening and diagnostic tests, perform procedures, and prescribe medications (no restrictions) and therapeutic interventions and can refer to specialists.

Nurse practitioners act as primary care providers within their stream of practice. They work independently across the spectrum of health services, such as acute care, primary care, community health, long-term care, specialty areas of health and emergency care. They work collaboratively with physicians and other health care professionals to provide high-quality, patient-centred care.

Nurse practitioners use a holistic approach to health care, focusing not only on medical issues or problems but also on patient/family-centred care including the psychosocial and functional aspects of life. Nurse practitioners provide patient education, and health promotion, and involve patients in care. They have been shown to consistently have

high rates of patient satisfaction with health outcomes when compared to the care provided by a family physician. Additionally, nurse practitioners provide timely access to care, especially in rural areas, relieving wait times and healthcare costs.

The LBD PCN Nurse Practitioner is working at 1.0 FTE in the previously underserved communities of Thorsby and Warburg. During this fiscal year, the Nurse Practitioner-Led Clinics had a panel of 483 patients, an increase of 16.9% over the previous fiscal year.



Testimony taken by the 2023 patient and caregiver experience survey for the nurse practitioner clinic:

“My visits are amongst the best interactions I have ever had within any medical community.”

QUALITY IMPROVEMENT PANEL MANAGEMENT

This program supports member physicians to validate patient panels and to pursue optimal screening for the purpose of the Patient's Medical Home and continuity of care.

The Quality Improvement Team annually assists our paneled primary care providers in ordering HQCA (Health Quality Council of Alberta) reports to understand their panels and identify areas for improvement.

To support the development of validated patient panels, the QI Team collects panel lists from each paneled primary care provider in the LBD PCN twice a year. The lists are analyzed to identify patients appearing on more than one panel. Each paneled primary care provider is provided with a list of their duplicated patients to support confirmation of primary care provider. The team offers assistance to primary care providers to improve their panel clean-up processes, with panel management processes and with ideal panel size calculations.

The Quality Improvement Team works with PCN multidisciplinary team members to enhance their knowledge of EMRs and improve the efficiency of their EMR processes.

The Quality Improvement Team regularly engages primary care providers who have not yet expressed interest in CII/CPAR.

WHAT IS CII/CPAR?

Community Information Integration and Central Patient Attachment Registry (CII/CPAR) enables physicians and their teams to share patient information to Alberta Netcare directly from their electronic medical record (EMR).

CII/CPAR enhances communication amongst providers by enabling the sharing of important healthcare information across the province. This two-way connection between clinic EMRs and Alberta Netcare is improving continuity of care between the Patient's Medical Home and Health Neighbourhood.

CII allows providers to send select patient information to Alberta Netcare including consult letters and information about patient visits to contribute to Community Encounter Digests (CEDs).

CPAR identifies relationships between patients and their primary provider and sends eNotifications to providers when their patients are seen in the emergency department, have a hospital admission or day surgery.

Primary care providers who express interest in CII/CPAR are assisted in completing paperwork, reviewing processes, and configuring their EMRs, if required. As of March 2024, 28 eligible primary care providers in the LBD PCN are routinely submitting verified panel information to CII CPAR.

ALBERTA FIND A DOCTOR

Connecting Albertans to a PCN primary care provider who is accepting new patients. This website is maintained by all 39 PCNs and lists family physicians and nurse practitioners who are accepting patients into their practice.

The demand for family doctors in the Edmonton area and provincewide continues to soar, with the albertafindadoctor.ca website reporting huge increases in visits over the past several years as the number of physicians taking patients continues to decline.

There were 1,184,948 visits to the website from April 1, 2023, to March 31, 2024, a 28% increase from the previous fiscal year. There were only 164 doctors and nurse practitioners accepting patients within this fiscal year. As of March 31, 2024, there were just 31 physicians and 4 nurse practitioners in the Edmonton area accepting patients. [See this infographic for more details.](#)

In the Edmonton Zone, patient attachment assistants support this work.

www.AlbertaFindADoctor.ca

PRESCRIPTION TO GET ACTIVE

A primary prevention program to support physical activity for at-risk patients. Created at our PCN in 2011, Prescription to Get Active (RxTGA) has fared well through the pandemic as more healthcare professionals than ever are utilizing the specialized physical activity prescription to help prevent and treat many chronic conditions. As of this fiscal reporting period, Prescription To Get Active reports the following enrollment in the program:

- 75% of PCNs, 17 AHS departments
- 1,060 medical clinics
- 150 recreation and fitness partners
- 20% annual growth

RxTGA continues to add value to our health care members by making it easier than ever for prescribers to refer to our program. The RxTGA form is now on most EMRs, and there is the ability to provide a 'virtual' RxTGA through telephone or video consultations. A major focus for RxTGA has been to offer more value to your patients by providing access to physical activity opportunities that are meaningful to them: On-line video on demand movement and exercise sessions, trail route access, and free coaching support to help sustained physical activity.

www.PrescriptionToGetActive.com

AFTER-HOURS CLINICS

The LBD PCN has previously supported the communities of Leduc and Beaumont with after-hours access to primary care through the Leduc After-Hours Clinic (operating out of the Leduc Beaumont Devon Primary Care Network office) and the Beaumont After-Hours Clinic (operating out of Beaumont Medical). When the COVID-19 pandemic was declared, the decision was made to close these clinics so that the physicians who worked in them could preserve capacity for patients in their clinics and in hospital.

Due to physician capacity limitations, the Beaumont clinic remains closed. The LBDPCN physician membership has expressed interest in re-opening the Leduc After-Hours Clinic; our leadership team and board of directors is currently developing a plan to support after-hours demand.

BOARD OF DIRECTORS

Dr. Justin Balko - President

Dr. Gurpreet Dinsa - Vice President

Dr. Gerard Amanna - Secretary

Dr. Robert Simard- Treasurer

Dr. Rebecca Saunders

Dr. David Tran

Dr. Anton du Toit

Patricia Matusko - Public Director

Jason Sheehy - LBD PCN Executive Director

Bridget Wiafe - Alberta Health Services Senior Consultant
(Governance Representative)

Heather Durstling - AHS Executive Director, Suburban
Hospitals, Edmonton Zone (Governance Representative)

COMMITTEES

Finance Committee

Dr. Robert Simard - Finance and Audit, Physician Lead

Jason Sheehy - Chair, PCN Executive Director

Shelley MacEachern – Manager, Administration & Finance

Shelley Deprez - PCN Executive Assistant, recorder

Team-Based Care Committee

Lori Briggs - Chair, TBC Manager

Dr. Gurpreet Dinsa - TBC Physician Lead

Dr. Jana Holden - TBC Member Physician

Dr. Rebecca Saunders - TBC Member Physician

Dawn Estey - AHS, Manager, Primary Care/Chronic Disease Management

Vacant - PCN Mental Health Clinician, Practice Lead

Michelle Williams - PCN Nurse Practitioner

Jason Sheehy, PCN Executive Director

Penny Garton - PCN Team Lead, Clinical Administrator, recorder

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