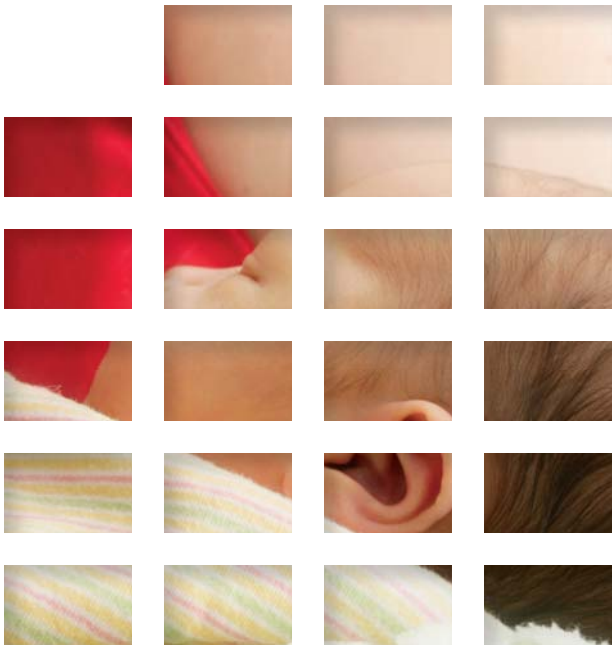
08

Building our capacity for care



Primary Care Network
CALGARY FOOTHILLS

DELIVERING INNOVATIVE HEALTH SOLUTIONS FOR FAMILY PHYSICIANS AND THEIR PATIENTS

ONE PERSON CAN DO A LITTLE WORK. 200+ CAN DO A LOT OF WORK AND MAKE A REAL DIFFERENCE.

AND THAT'S HOW THE CALGARY FOOTHILLS PRIMARY CARE NETWORK IS MAKING A REAL DIFFERENCE IN THE LIVES OF THE PATIENTS THAT OUR NETWORK PHYSICIANS SERVE.

This report highlights the hard work, imagination, and dedicated efforts of the medical directors and leads, our employees, board, committee and network members, all of whom have made exceptional contributions to our progress in 2008.

Our work is about improving primary medical care for people who live in northwest Calgary and Cochrane, as well as enhancing both the environment in which family physicians in these areas practice and the resources they have available for their patients.

As a primary care network, we are now well into our third year of operation and have experienced rapid growth as we developed and delivered a number of exciting and relevant new programs and services during the past year. However, I think one of most valuable things we do is to listen to you, our members. We've heard how challenging it is for family practitioners, we're aware of the issues you confront, and we appreciate what it takes for you to be out there "on the front lines" every day.

As any practiced physician knows, acute observation and accurate diagnoses are critical to how effectively we meet our patients' medical needs. The same holds true for the overall framework in which we practice our profession. That's why listening carefully, responding thoughtfully, and taking full advantage of collaborative opportunities are priorities for our organization.

Those same qualities enable us to be at the leading edge of solutions, whether it's pioneering new ways to approach the area of property supports for office management, how we facilitate improved relationships and accessibility between specialists and family physicians, how we help reintegrate the role of family physicians with early stage obstetric care, or how we enable comprehensive levels of team work where physicians are generously supported by other health care professionals.

The level of interest and support from network members in 2008 has been very gratifying.

I would like to recognize the efforts of Dr. Mike Foster and Dr. Janet Reynolds in 2008, as they leave the FPCP Board after two years of thoughtful contributions. Janet has provided a strong representation for large clinics and her own special level headed input. Mike has ably represented the Cochrane area and supported our mixed rural and urban Primary Care Network. I would also like to extend my sincere thanks to all Board members who have freely contributed of their time and multiple talents over the past year.

At the Calgary Foothills Primary Care Network, we are focused on creating a new world of providing care, one in which doctors can see themselves as both energized by and engaged in. We're here as a resource for you and are working to make your journey a bit easier.

On behalf of the Board of Directors,

DR. JUNE BERGMAN / CHAIRMAN

THE CALGARY FOOTHILLS PRIMARY CARE NETWORK'S FOCUS IS ON FAMILY PHYSICIANS AND THEIR PATIENTS.

WE DELIVER INNOVATIVE HEALTH CARE SOLUTIONS THAT ARE STRENGTHENING AND EXTENDING THE CAPACITY OF NORTHWEST CALGARY AND COCHRANE'S FAMILY PHYSICIANS.

Our journey as a health network has continued at a brisk tempo and with an ever greater sense of urgency throughout 2008. If a single word could characterize what our group has demonstrated during the past year, it would be "flexibility". Our board members, medical directors, medical leads, and employees all exhibit enormous stores of this admirable trait, without which we would be unable to respond to the array of challenges before us.

All of you are well aware that we are experiencing a dramatic shortage of incoming family physicians. At the other end of the career spectrum, a number of family physicians in our city are approaching retirement.

While this continues to be a disturbing trend, I remain optimistic and very pleased to report that the CFPCN marked a number of major milestones throughout 2008 that are all focused on addressing this fundamental problem. In fact, everything we are doing is targeted at creating a more supportive environment that will attract more physicians into family practice.

Our milestones include:

- bringing together four low-risk obstetrics practices into a single Low-Risk Obstetrics Clinic in northwest Calgary, offering greater efficiency and greater depth of patient care for families pre-, during, and post-delivery;
- establishing the Chronic Disease Management clinic at the Crowfoot Centre in northwest Calgary, providing a vital resource for patients with complex, chronic illness who are unattached to a family physician;
- improving both access to and continuity of care through the AfterHours Clinic, which provides after hours health care to patients of our network with acute medical needs. Significant accomplishments have also been made in our In-Hospital, Mental Health, Seniors, and other program areas and I invite you to refer to the program ssection beginning on page 11;
- growing exponentially as an organization and as a network – from a group of 15 employees in March 2007 to a staff of 47 employees in March 2008. We also enlarged the membership of physicians in our network to 234 members today from 152 in 2007. We're trying to lead in terms of what a Primary Care Network can be and, at the same time, create a place where people feel comfortable expressing their views and feel that they have been heard;
- making unique and creative progress on ways to assist family physicians who are struggling to maintain their practices in the current high-cost environment. For example, we're working with property management companies to identify ways to make it easier and more cost effective for family physicians to house their practices;
- forging progressive partnerships with those with whom we share common interests, whether it's the private sector, PCN colleagues, or Alberta Health Services Calgary - our formal partner.

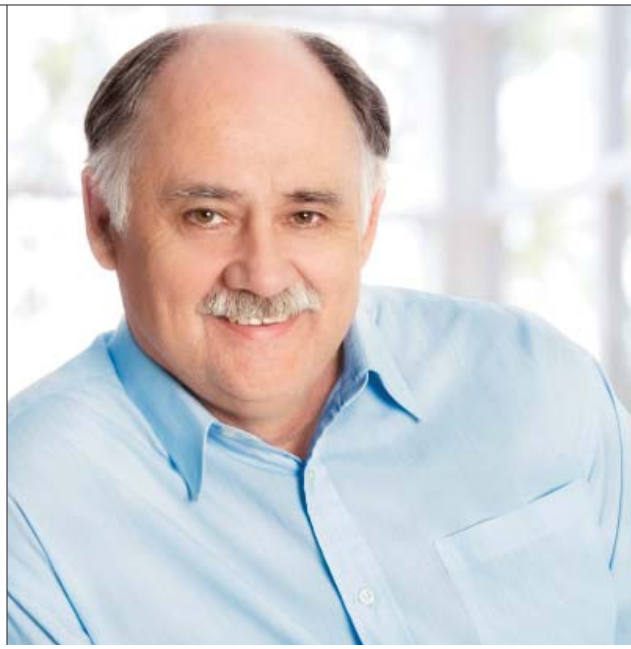
As we move forward, we are transitioning from launching new programs to focusing on the function and impact of our programs in the community. That means coming to a deeper understanding of how our programs are working together, looking at program nuances and fine-tuning opportunities, identifying ways programs can be more seamless for patients, and ensuring that information flow from each area is meeting physicians' needs.

In essence, what we are doing is answering the question, "What does family medicine look like in 2008, and beyond?"

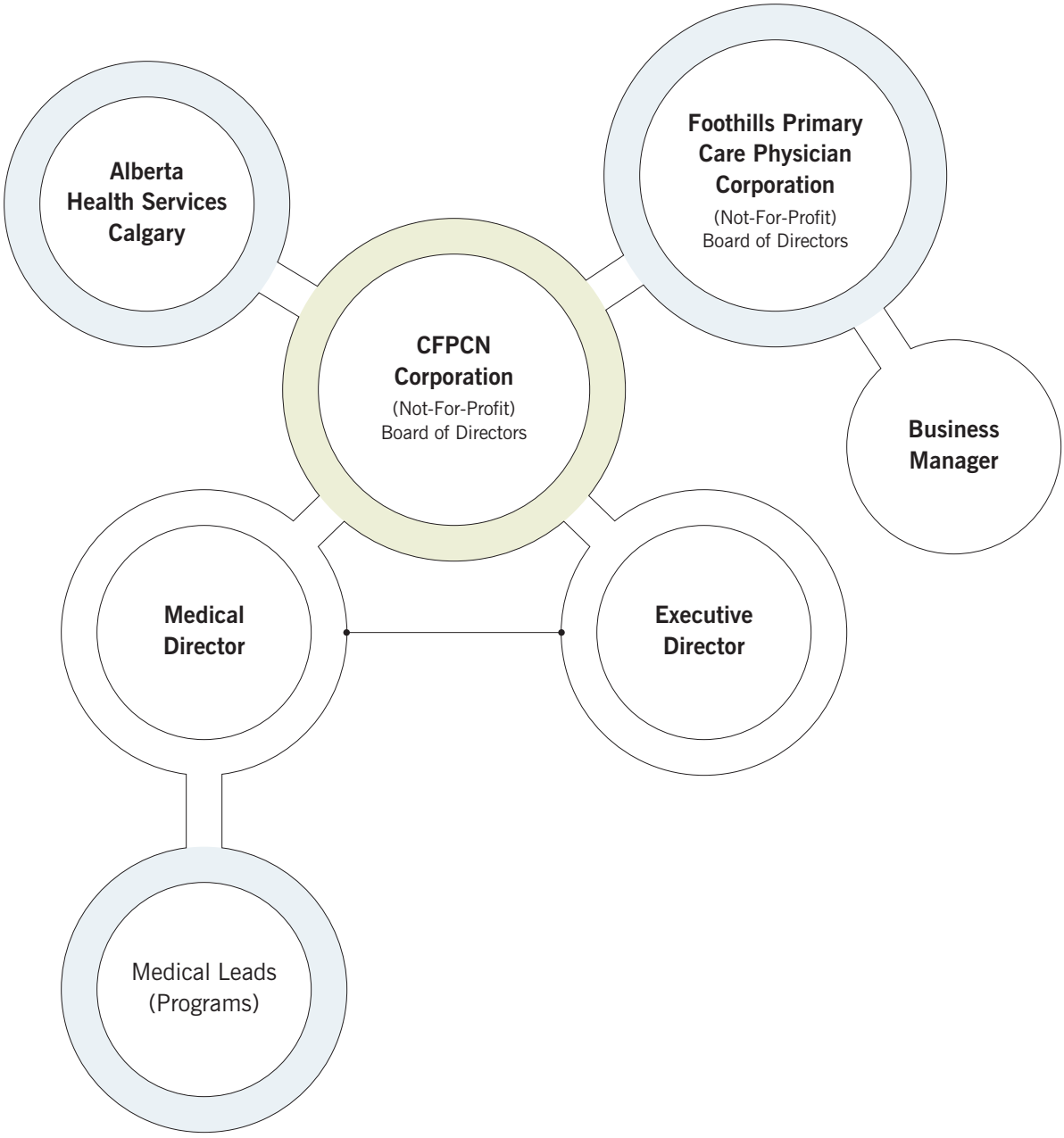
The growth of our network and the confidence exhibited in our work suggests that we are on the right path. We appreciate your ongoing input and involvement and look forward to our continued shared success.

Sincerely,

LARRY MCLENNAN / EXECUTIVE DIRECTOR



CFPCN Organizational Chart



How We Operate

The Calgary Foothills Primary Care Network is operated through two boards of directors. The Foothills Primary Care Physician Corporation board is invested with the responsibility of representing physician interests and overseeing the quality of care and business of the corporation.

Foothills Primary Care Physician Corporation Board of Directors

Dr. June Bergman, **CHAIR**
Dr. Remo di Palma, **VICE-CHAIR**
Dr. Mohammed Abdel-Hafez
Dr. Elaine Bland
Dr. Leslie Ellestad
Dr. Mike Foster
Dr. Bill Hall
Dr. Dennis Hayes
Dr. Janet Reynolds
Dr. Roger Thomas

Calgary Foothills Primary Care Network Medical Directors

Dr. Peggy Aufricht
Dr. Dennis Fundytus

Left to right: **Dr. Mohammed Abdel-Hafez, Dr. Dennis Fundytus, Dr. Leslie Ellestad, Dr. Remo di Palma, Dr. June Bergman, Dr. Dennis Hayes, Dr. Janet Reynolds, Dr. Bill Hall (front), Dr. Mike Foster, Dr. Elaine Bland.**

The Calgary Foothills Primary Care Network board is responsible for the design, implementation and administration of the medical programs and services provided by the network. Each is composed of committed volunteers, most who are family physicians themselves, who work to promote the level of support available for family physicians within the Calgary Foothills region.

Calgary Foothills Primary Care Network Board of Directors

Dr. June Bergman, **CO-CHAIR**

Dr. Rollie Nichol, **CO-CHAIR**

Dr. Rob Abernethy

Mr. Jim Merchant

Dr. Remo di Palma

(One member float from the FPCP Board, which rotates on a monthly basis.)

Medical Leads (Programs)

Dr. Terri Staniland
AFTERHOURS CARE PROGRAM

Dr. Richard Ward
CHRONIC DISEASE MANAGEMENT PROGRAM

Dr. Sarb Grewal
IN-HOSPITAL CARE PROGRAM

Dr. Mark Joyce
MENTAL HEALTH PROGRAM

Dr. Sanjeev Bhatla
OBSTETRICAL CARE PROGRAM

Dr. Karen Seigel
POPULATION HEALTH PROGRAM

Dr. Doug Lampard, Dr. Paddy Quail
SENIORS CARE PROGRAM

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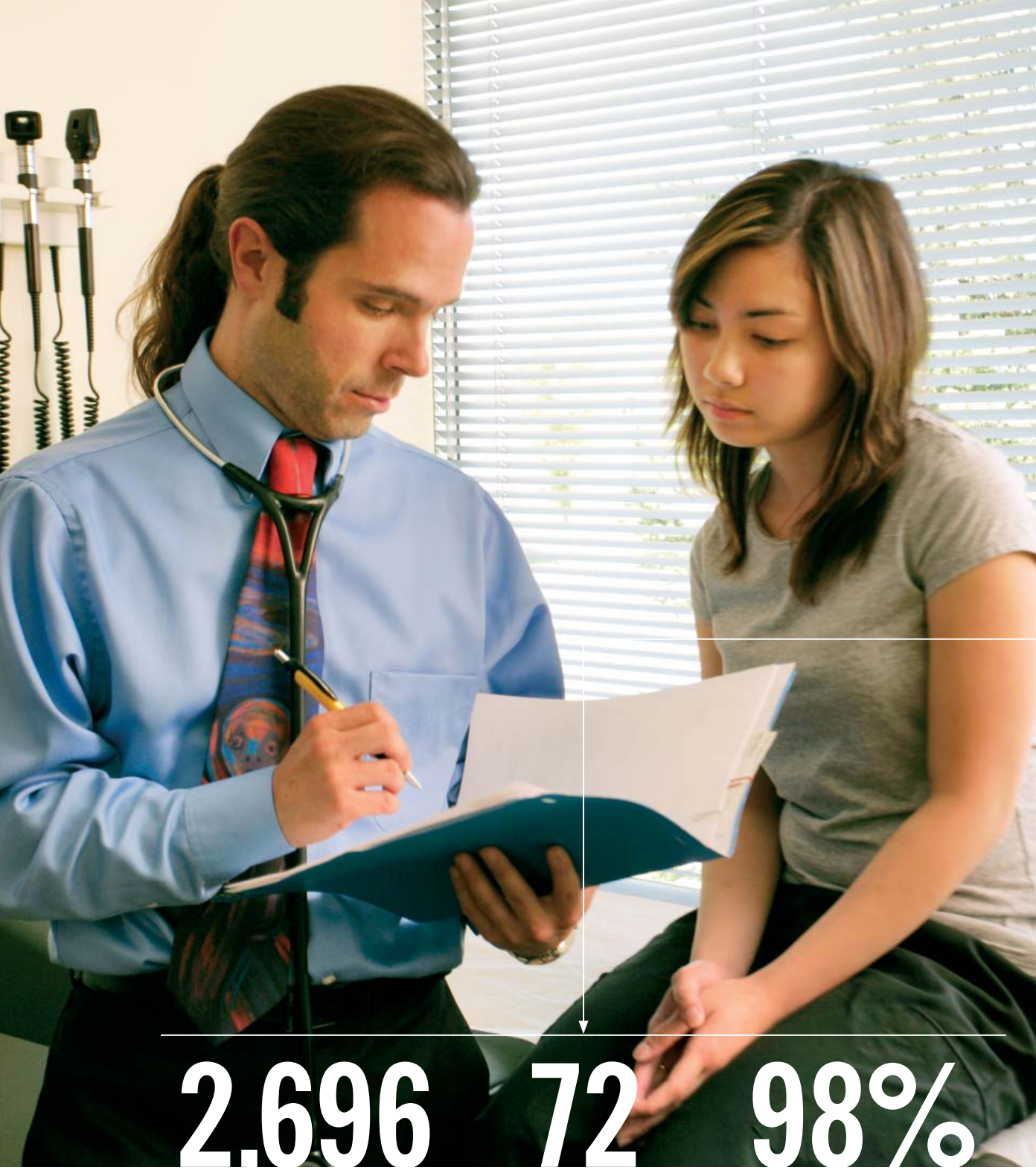
Primary care is sometimes referred to as the "medical home" for a patient, where their individual health care needs are met in a continuous and integrated manner. In the more than two years the Calgary Foothills Primary Care Network has been operating, our organization has launched eight distinct and targeted primary care programs in the northwest Calgary and Cochrane communities.

While the individual goals of each program vary, all have been designed to help increase access to primary care, to increase emphasis on health promotion and disease and injury prevention, to improve care of medically complex patients and patients with chronic disease, to improve coordination and integration with other health care services, and to support wider use of multidisciplinary teams in primary health care delivery. All are factors proven to lead to more positive, sustainable health outcomes for patients.

Each program is championed by a Medical Lead, who, in concert with the CFPCN board and each health care team, is responsible for program design, implementation, and ongoing quality of service delivery.

Programs



2,696 **72** **98%**

To date, the AfterHours Clinic:

- → **sees approximately 20 - 25 patients on week nights and between 28 - 35 patients during weekends; Health Link receives an average of 2,696 calls per month from CFPCN patients.**
- → **has 72 CFPCN physicians (31%) picking up shifts and working at the clinic.**
- → **recorded that the majority (98%) of patients were either "satisfied" or "very satisfied" with the care received.**

"Overall, the AfterHours Care program has been really well accepted. More than a third of our member physicians have expressed an interest in working at the clinic, and they appreciate knowing their patients are well taken care of. We also sense that the clinic is helping to remove the sense of isolation that family docs in their own practices often experience. It's a great way to meet other doctors and be part of a caring community. Our approach also offers doctors the opportunity to spend more time with patients and exposes them to more acute family medicine issues. There's also really close mentoring and teaching opportunities for the residents."

DR. TERRI STANILAND / MEDICAL LEAD, AFTERHOURS CARE PROGRAM

AfterHours Care Program

The CFPCN AfterHours Care Program's objectives are to 1) provide appropriate evening, weekend, and statutory holiday support for attached and unattached patients when family physicians' offices are closed, and 2) provide strong continuity of care for patients who are seen in the after-hours clinic, ensuring their family physicians receive timely updates about the after hours visit

The AfterHours Care Program has three components: the AfterHours Clinic, physician on call services (including the Cochrane on call group), and a partnership with Health Link.

The AfterHours Clinic is located at the Riley Park site: 130, 1402 – 8th Avenue NW. Two physicians, a nurse, two residents, and a receptionist staff the facility Monday through Friday from 5:00 through 9:00 and Saturday, Sunday, and statutory holidays from 10:00 a.m. through 4:00 p.m. Cochrane physicians have an afterhours call schedule as well as extended office hours for patients residing in Cochrane.

Patients access the AfterHours Clinic in one of two ways.

- → CFPCN physicians direct their patients to call Health Link if they experience a medical problem after office hours. Health Link triages the calls and when necessary, refers patients to the clinic.
- → CFPCN physicians fax the clinic if they are fully booked and have received a call from a patient needing an urgent appointment. The clinic receives the faxes and contacts patients directly for a same-day appointment.

92 **9** **4.7**

To date, the Chronic Disease Management Program:

- → **has 92 (39%) CFPCN member physicians involved in the CFPCN-AHS multidisciplinary team partnership.**
- → **has 9 full time equivalent (FTE) chronic disease nurses providing care in partnership with 92 physicians to address the needs of patients with diabetes, hypertension and dyslipidemia.**
- → **has 4.7 full time equivalent (FTE) pharmacists working in partnership with 88 physicians to help care for hypertension patients.**

"A significant achievement for the CFPCN is the establishment of the unattached patient clinic, providing a service for complex illnesses. It's very timely. A study just released in Ontario has confirmed increased hospital emergency visits and issues associated with unattached patients with chronic diseases like hypertension and diabetes. We assign the patients we work with to a team member who becomes their case manager. This helps lighten the load and enlarges the capacity of each physician in our clinic, and helps ensure patients are receiving the services and oversight they need. It feels like we're doing important work, identifying gaps and helping to fill those gaps. It's been very personally rewarding."

DR. RICHARD WARD / MEDICAL LEAD, CHRONIC DISEASE MANAGEMENT PROGRAM

Chronic Disease Management Program

The major initiatives within the CFPCN's Chronic Disease Management Program include multidisciplinary teams in partnership with Alberta Health Services Calgary, the Unattached Patient Clinic, the Hypertension Initiative, and Clinical Pharmacist Services.

Building on AHS Calgary programming, CFPCN physicians may refer patients to members of a multidisciplinary team housed in the physician's office, which may include chronic disease nurses, respiratory educators, DHCC diabetes educators, dieticians, behavioural health consultants, and pharmacists. This interdisciplinary approach is thought to be the most effective way to treat chronic diseases such as diabetes, dyslipidemia, hypertension, chronic obstructive pulmonary disease, and asthma.

The Calgary Foothills Primary Care Centre (Unattached Patient Clinic) is a multidisciplinary clinic for unattached and complex patients in the CFPCN's catchment area. Unattached patients can self-refer and are also accepted from any AHS Calgary health care setting such as hospitals, outpatient clinics, emergency departments, and Home Care.

The Hypertension Initiative is a one-year pilot project using CFPCN pharmacists in primary care offices with a pay-for-performance strategy. Current research links pharmacists in primary care with improved health outcomes, which include reduced blood pressure targets, decreased cholesterol levels, and increased treatment adherence.

128 **572** **76**

To date, the In-Hospital Care Program:

- → **128 (55%) CFPCN physicians have had patients admitted to the program between March 2007 and March 2008.**
- → **has seen 572 patients from April 2007 to March 2008.**
- → **average patient age is 76 years.**

"We've seen positive progress this year – at getting more family doctors into the hospitals, improving connections between them, improving the level of hospital care, and working to provide a high level of family support, with good discharge and follow-up practices. Many of the issues we deal with are linked to advanced age and our nurses are very involved in supporting families to ensure that patients can thrive when discharged and maintain independence. ✱ The CFPCN has doubled in size and the number of patients has also doubled, such that our In-Hospital Care Program is always fully subscribed. We've captured the full 24 spots and have a target of increasing our intake to 36 patients in late 2009."

DR. SARB GREWAL / MEDICAL LEAD, IN-HOSPITAL CARE PROGRAM

In-Hospital Care Program

The objectives of the CFPCN's In-Hospital Care Program are to provide an opportunity for community-based family physicians to work in a hospital setting and to provide better continuity and links for patients between the acute and primary care settings.

A sub-group of CFPCN physicians is available, on a rotational basis, to assume inpatient care duties for 24 PCN patients at Foothills Medical Centre.

This service, which was the first program offered by the CFPCN in October 2006, is intended to address the needs of those patients whose presenting medical problems at FMC are appropriate for Family Medicine level care. Clear benefits have been realized from improving patient transitions between the community and the hospital, and the program is facilitating communication and transfers of health record information, reconciliations of medications, and early follow-up for patients after discharge from the hospital.

3.5 **2/08** **36**

To date, the Mental Health Program:

- → employs 3.5 full time equivalent (FTE) Behavioural Health Consultants in 18 clinics supporting 63 (27%) physicians.
- → introduced tele-psychiatry to the network in February 2008.
- → provided consultations to patients whose average age is 36.

"The thrust of our mental health program is to demystify and normalize the provision of mental health services in the primary care setting. By introducing and incorporating mental health practitioners into the primary care system, we've helped a number of family physicians elevate the scope and quality of the mental health care available to their patients. ✱ We've also enabled easier and more direct communication between physicians and psychiatrists. Part of the demystifying process involves re-labelling mental health as behavioural health and going beyond a narrow definition focused on depression, anxiety, and addiction issues. We've broadened this to include areas like smoking cessation, weight control, exercise, and lifestyle issues."

DR. MARK JOYCE / MEDICAL LEAD, MENTAL HEALTH PROGRAM

Mental Health Program

Integrating mental health professionals within primary care teams is the central focus of the behavioural health consultation model the CFPCN is advocating and implementing in our Mental Health Program.

The objectives of the program are two-fold; helping family physicians care for patients with mental health concerns and improving access to mental health services and providers for both family physicians and their patients. The program responds to the preference expressed by the majority of member physicians who favour treating mental health concerns in their primary care office with support.

CFPCN initiated the Behavioural Health Consultant model in physician practices in the fall of 2007, placing mental health consultants in family physician offices as part of a multidisciplinary team.

The tele-psychiatry initiative, established in February 2008, offers brief phone consultations with a psychiatrist for family physicians around specific patient issues.

The CFPCN also offered three health education classes on Setting and Achieving Goals, Stress, and Finding Lifestyle Balance, which were taught by the CFPCN Mental Health Program Manager and Behavioural Health Consultants.

30 **300**

To date, the Obstetrical Care Program:

- → **has 30 physicians seeing patients at the new Calgary Foothills Primary Care Obstetrical Centre.**
- → **has increased capacity from 225 to 300 low-risk deliveries per month.**

"Our big accomplishment this year was bringing four previously separate low-risk obstetrics practices together into one single location. It's enabling us to deliver more consistent care for patients, while pooling resources and expertise. We now have the critical volumes to offer specialist services, such as breast-feeding consultants and dieticians, in an accessible, one-stop shopping option for the patient. ✱ We've also aggressively recruited additional obstetricians and we're championing a shared pre-natal care model with family doctors. Our message is that pregnancy is part of family medicine and we want to maintain a connection between family physicians and their patients."

DR. SANJEEV BHATLA / MEDICAL LEAD, OBSTETRICAL CARE PROGRAM

Obstetrical Care Program

Providing high-quality obstetrical care for women with low-risk pregnancies is the goal of CFPCN's Obstetrical Care Program. A major step towards this goal was achieved this year through the amalgamation of four obstetrics practices at the new Calgary Foothills Primary Care Obstetrical Centre (130, 1402 – 8th Avenue NW). The vision for the centre is to be accessible to every pregnant woman in the CFPCN's catchment area who needs care.

This approach has increased the capacity of the Centre's physicians through teamwork, operational efficiencies, and improved communication and coordination along the continuum of obstetrical care through antepartum, intrapartum, and postpartum care.

309 45 8

To date, the Population Health Program:

- → **received 309 referrals (as of October 2008) for the Tobacco Cessation program at the Calgary Foothills Primary Care Centre.**
- → **supports a peer-led, year-round walking program with more than 45 participants.**
- → **offers TrymGym – an 8-week accredited weight management program.**

"The population health focus thus far has been health promotion. The biggest program success this year has been getting the tobacco cessation program up and running. This brings together education, medication, and support under one roof. We are finding that having physicians discuss the program is promoting quitting, even before some of these patients attend classes. ✱ In addition, we have recently obtained health data from the region about our population. This is very exciting since it will allow us to identify gaps in health within our catchment area and tailor our initiatives to address these gaps. As well, we have spent a lot of time on evaluation of the existing PCN initiatives and are planning strategies to expand on this as we move forward."

DR. KAREN SEIGEL / MEDICAL LEAD, POPULATION HEALTH PROGRAM

Population Health Program

The CFPCN's Population Health Program is designed to enable member physicians to effectively interact with their communities, identify service needs, and address those needs in ways that best fit their patient population.

Three major programs are currently addressing the needs of northwest Calgary and Cochrane populations by encouraging smoking cessation, promoting regular physical activity, and targeting obesity through a comprehensive weight management program.

Through the Tobacco Cessation Program at the Calgary Foothills Primary Care Centre, participants receive tobacco cessation education in small group settings, and are offered pharmacotherapy with the permission of their family physician.

The CFPCN supports a peer-led walking program inside North Hill Centre , in Cochrane, and in Confederation Park in the summer months. North Hill "mall walkers" also have the option to participate in monthly education sessions led by dieticians or pharmacists.

The TrymGym program is offered to PCN patients in partnership with the University of Calgary. It is an 8-week accredited weight management program with behaviour change, nutrition education, and physical activity components.

1/08 2,500 BCS

To date, the Seniors Care Program:

- established the Foothills Long-Term Care On-Call Group in January 2008.
- Long-Term Care On-Call Group physicians responsible for 2,500 patients in long-term care facilities during the on-call shifts.
- is piloting a nurse practitioner project designed to assist physicians and their patients residing at the Bethany Care Society facility in Cochrane.

"The big step forward we've made so far is in setting up the Long-Term Care On-Call group, with a long-term care orientation to it. We have a good cadre of physicians who are responsive and focused on seniors. We're significantly busy. We have 2,500 patient beds to cover when we're on call, so a lot of issues can arise. Many of the patients we care for suffer from dementia, and so it is their families whom we interact with. Getting people to think about end of life care and clarifying care expectations are among the more challenging issues we confront."

DR. DOUG LAMPARD, DR. PADDY QUAIL / MEDICAL LEADS, SENIORS CARE PROGRAM

Seniors Care Program

The CFPCN's Seniors Care Program is designed to support family physicians in providing comprehensive care to their aging patient populations, as well as improving standards of care in long-term care facilities.

Two major initiatives have been developed by the CFPCN's Seniors Care Program to date. The first, the Foothills Long-Term Care On-Call Group, began operating in January 2008. A total of 32 network physicians are participating in the On-Call Group, providing after hours coverage on weekdays and weekends for their patients who reside in long-term care facilities. Each physician takes on call responsibilities for a one-week period.

The second initiative involves the hiring of a nurse practitioner, who works at the Bethany Cochrane long-term care facility as part of a pilot project. The intent is to evaluate the effectiveness of the Nurse Practitioner role in assisting physicians with their workloads, as well as in providing care to residents in a timely manner, decreasing visits to emergency, increasing communication between physicians and family members, and providing educational opportunities for staff.

Office Support Program

The CFPCN offers its member physicians a number of practical ways by which they can save time and money, as well as managing their schedules more efficiently – all while contributing to better care for their patients. Recently introduced services include the formation of relationships with real-estate management companies to investigate ways to develop more affordable medical office space. The Office Support program also is responsible for engaging member physicians in CFPCN's activities.

The CFPCN has the capacity to provide clinical office efficiency tools and resources to help family physicians increase their productivity and effectiveness. An example of this is the offering of small business seminars for member physicians who are interested in furthering their knowledge in clinic operations and administration, including financial management. The challenges of operating community offices in an environment of rapidly rising expenses and human resource constraints are considerable. Accordingly, the CFPCN offers a Staff Retention program designed to assist member physicians in attracting and retaining office staff. The CFPCN also offers opportunities for cost savings through participation in purchase programs for office and standard medical supplies.

The CFPCN supports time away for family physicians through the Office Access Support Fee. In order to qualify for the fee, the physician's office must remain open and patients must have access to care during the absence, thereby maintaining continuity of care for the patients within the practice.

A Nursing Support Fee is also available, to encourage family physicians to hire Registered Nurses, Licensed Practical Nurses, or EMTs as staff for patient care.

The Continuity and Communications Fee (C&C Fee) is designed to compensate member physicians who participate in the communications-related activities of the PCN. These include, but are not limited to: communicating with their patient base about the PCN and its programs; attending the AGM, town hall meetings, community forums, and other meetings of stakeholder groups within the PCN; communicating with other PCN physicians re: shared patient care; meeting regularly with their liaison nurse; and communicating with PCN staff, other physicians, and CHR staff about relevant PCN business.

Auditors' Report

To the Board of Directors of
Calgary Foothills Primary Care Network

We have audited the Statement of Operations, Schedule of Expenses by Payment Type, and the Summary of Financial Position of the Calgary Foothills Primary Care Network as at March 31, 2008. These financial statements are the responsibility of the Primary Care Network's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statements presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Calgary Foothills Primary Care Network as at March 31, 2008 and the results of its operations for years then ended in accordance with the basis of accounting described in Note 1 to the financial statements.

The financial statements, which have not been, and were not intended to be, prepared in accordance with Canadian generally accepted accounting principles, are solely for the use of the Primary Care Initiative (an organization established by Alberta Health & Wellness) and the Directors of Calgary Foothills Primary Care Network to comply with the annual reporting guidelines of the Primary Care Initiative. These financial statements are not intended to be and should not be used by anyone other than the specified users or for any other purpose.

Calgary, Canada
June 20, 2008

Ernst & Young LLP **CHARTERED ACCOUNTANTS**

Statement of Operations

	BUDGET	ACTUAL	ACTUAL
	12 MONTHS ENDED MAR 31, 2008	12 MONTHS ENDED MAR 31, 2008	8 MONTHS ENDED MAR 31, 2008
	UNAUDITED	AUDITED	AUDITED
Revenue			
Per capita funding brought into revenue	$ 11,519,090	**$ 7,473,838**	$ 1,902,657
Capacity building grant funding brought into revenue	1,259,336	**30,579**	
Specialist linkages grant			
Pharmacist project grant			
Interest and investment income	150,000	**175,659**	125,350
Other	500,460	**444,537**	
Revenue total	13,428,886	**8,124,612**	2,028,007
Expenses			
In-Hospital Care Program	535,830	**702,105**	261,751
Obstetrics	1,557,734	**1,012,878**	92,567
After-Hours Care	1,499,674	**1,107,438**	78,118
Office Supports	2,274,540	**1,804,556**	703,400
Chronic Disease Management	3,756,063	**1,247,792**	184,750
Mental Health	759,694	**196,563**	15,000
Seniors Health	542,599	**149,810**	15,000
Population Health	417,382	**35,992**	15,000
CFPCN Board	150,000	**177,530**	–
Academic Support	200,000	**25,124**	15,000
Expenses for priority initiatives	11,693,516	**6,459,788**	1,380,586
Evaluation	120,000	**25,000**	
Other central administration	964,911	**1,019,629**	522,071
Contingency + other unallocated funds	–	**–**	–
Expenses for central allocations	1,084,911	**1,044,629**	522,071
Total expenses	12,778,426	**7,504,417**	1,902,657
Revenue less expenses this year	650,460	**620,195**	125,350
Net assets (deficit) beginning of year	125,350	**125,350**	–
Net assets (deficit) end of this year	$ 775,810	**$ 745,545**	$ 125,350
Per capita payments received	n/a	**3,360,225**	7,295,117
Capacity building grant payments received	n/a	**629,668**	629,668

Schedule of Expenses by Payment Type

	BUDGET 12 MONTHS ENDED MAR 31, 2008 UNAUDITED	ACTUAL 12 MONTHS ENDED MAR 31, 2008 AUDITED	ACTUAL 8 MONTHS ENDED MAR 31, 2008 AUDITED
Physicians: clinical	$ 3,898,260	**$ 1,810,575**	$ 1,356,594
Physicians: administrative	160,000	**237,291**	
Physicians: other	1,792,000	**2,067,400**	–
Physicians subtotal	5,850,260	**4,115,267**	1,356,594
Non-physician direct care providers	2,205,704	**881,841**	74,001
Other expenses + contingency	4,722,462	**2,507,309**	472,062
Total expenses	$ 12,778,426	**$ 7,504,417**	$ 1,902,657

Summary of Financial Position

	ACTUAL 12 MONTHS ENDED MAR 31, 2008 AUDITED	ACTUAL 8 MONTHS ENDED MAR 31, 2008 AUDITED
Cash	**$ 961,644**	$ 6,141,008
Investments	**3,200,000**	
Other assets	**166,639**	639,031
Total assets	**4,328,283**	6,780,039
Deferred revenue	**2,507,604**	6,022,128
Other liabilities	**1,075,134**	632,562
Total liabilities	**3,582,738**	6,654,689
Net assets	**745,545**	125,350
Total liabilities and net assets	**4,328,283**	6,780,039

Notes to Financial Statements

1) Accounting policy

The financial statements have been prepared in accordance with the reporting guidelines of the Alberta Primary Care Initiative, an organization established by Alberta Health and Wellness to oversee the services of Alberta's Primary Care Networks. The guidelines include the requirement to recognize funding revenue in each reporting period only to the extent the related expenditures have been incurred, with any unspent funds recorded in deferred revenues.

2) Prior period adjustments

Effective April 1, 2007, the Calgary Foothills Primary Care Network was required to adopt the method for revenue recognition described in Note 1 above. As a result, the prior year revenue amount was adjusted to reflect the adoption of this new policy for comparative purpose.

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CALGARY FOOTHILLS

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