PrimaryCare Network
CALGARY FOOTHILLS

ANNUAL REPORT 2009

Building our capacity for care

THE CALGARY FOOTHILLS PRIMARY CARE NETWORK CONTINUES TO MAKE MEANINGFUL IMPROVEMENTS TO THE HEALTH OF PEOPLE SERVED BY FAMILY DOCTORS IN NORTHWEST CALGARY AND COCHRANE.

The primary care network model is a joint venture between a group of family doctors working in conjunction with Alberta Health Services to co-ordinate the delivery of primary health care for their patients.

From the outset, the Calgary Foothills Primary Care Network has been especially fortunate to have attracted dedicated members who serve on both our CFPCN Board of Directors and our Physician Corporation Board. Their contributions have been made with the express interest of improving the quality of care physicians are able to offer their patients. We've been equally fortunate to have a cadre of high-calibre, talented employees who work tirelessly to provide innovation in the delivery of health programming. Our members also provide tremendous support in sustaining our programs and putting them to use to best care for our populations.

We've made clear progress on our "big picture" organizational goals – of strengthening the functionality of our boards, of working to develop a new business plan, and of identifying strategies for significant improvements in services to people.

2009 has been a transitional year for our employees, boards, and members. We've made clear progress on our "big picture" organizational goals – of strengthening the functionality of our boards, of working to develop a new business plan, and of identifying strategies for significant improvements in services to people. We've also taken the time to look beyond our current framework and carefully consider other things our network could be doing.

With this in mind, our Physician Corporation Board has struck six new committees during the past year – Governance and Nominating, Partnerships, Advocacy, Quality, Specialist Referral, and Membership Review – to further mine the richness of our board and members' talents and to explore new opportunities.

Much time and effort has also been invested over 2009 in conducting a critical analysis of our existing programming. Our goal is to develop more defined indicators of activity and outcome. That means understanding how we can best generate the infrastructure of information we need and I'd like to extend particular thanks to Dr. Bill Hall (Medical Director) for his leadership in moving this important initiative forward.

I would also like to recognize our two previous Medical Directors – Dr. Peggy Aufricht and Dr. Dennis Fundytus, who stepped down in 2009 and who have each brought instrumental insight to the network. Both physicians have continued to contribute to our board operations.

The coming year promises to be exciting as we embark on a new three year approved business plan. As we look forward into 2010, we continue to value the trust our member physicians place in our organization and welcome a year of new partnerships, innovation, and continual improvement.

On behalf of the Physician Corporation Board of Directors,

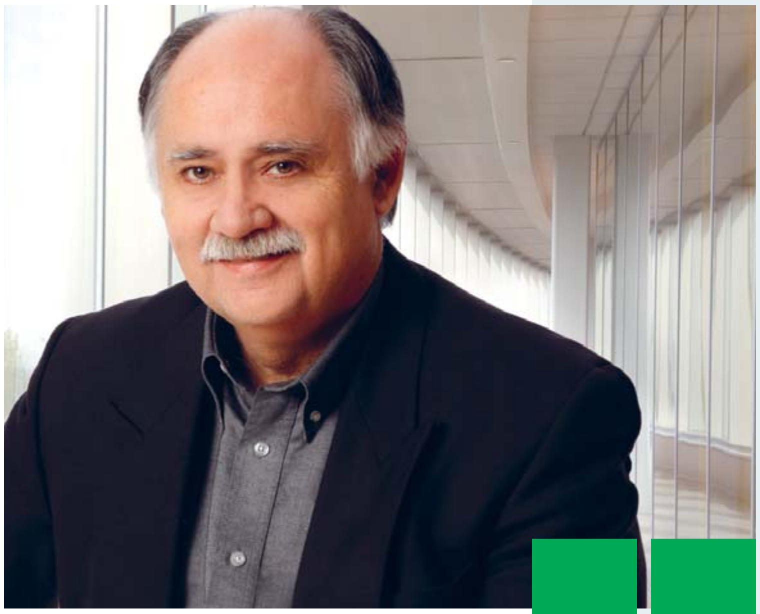
DR. JUNE BERGMAN / CHAIRMAN

Developing innovative, workable solutions to address the challenges faced by family physicians is what we do.

We are proud of the progress that has been made over the three and a half short years since we started. Our network continues to make a meaningful difference to our members as well as making significant inroads in improving the health of people in northwest Calgary and Cochrane.

There are now eight primary care programs firmly embedded in the communities we serve and they are supporting physicians in meeting myriad patient needs. These programs include low-risk obstetrics, chronic disease management, mental health support, in-hospital care, population health, seniors care, an office supports initiative, and an after hours clinic. (For more information on our programs see page 6).

While it takes considerable effort to develop and launch relevant health programs, they also require continual fine-tuning and adjustment to ensure they keep running efficiently while addressing identified needs. The Board of Directors will soon be undertaking a complete review of all the CFPCN programs to ensure that they are meeting the needs of our members and the population they serve.



In 2009, we took full advantage of the opportunity to begin a serious assessment of where we are going and what we need to look like in order to arrive at a sensible and sustainable balance between costs and program delivery.

Some of the milestones that were part of 2009 include:

- Completion of the 2009-2012 business plan.
- Initiating six new committees, with members from our Board as well as from the general membership to help guide our organization. We recognize our success depends on engaging effectively with our members and these committees will enable us to broaden our reach and promote the growth of our organization.
- Further developing the liaison model to connect directly with our member physicians and ensure they are receiving the information they need from us and that we are hearing from them.
- Laying the groundwork for an objective and rigorous evaluation of our efforts. Assessment, feedback, and checkpoints are increasingly important. So is flexibility. We recognize that we can't be all things to all people and want to more systematically and objectively assess our efforts.

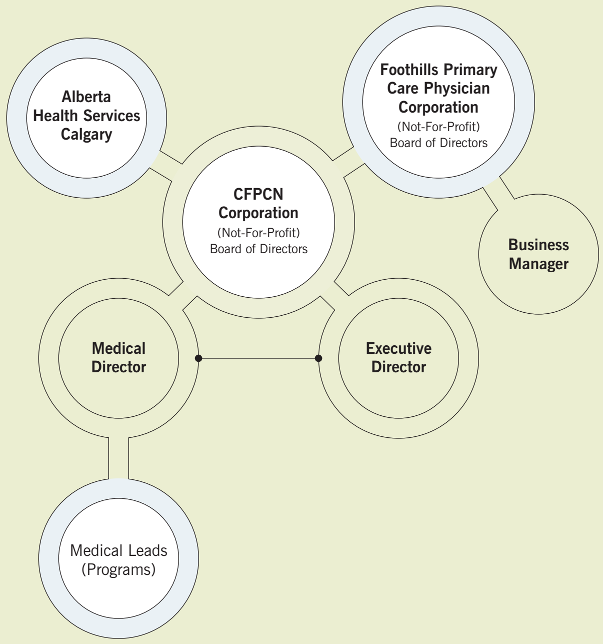
Quite simply, the work we do depends on the involvement and interest of our members. Our overarching focus continues to be on the challenges faced by family physicians and as we look forward into 2010 and beyond, we remain optimistic that our efforts as a healthcare innovator and facilitator will continue to provide valued support.

Sincerely,

LARRY MCLENNAN / EXECUTIVE DIRECTOR

Foothills Primary Care Physician Corporation Board of Directors (left to right)
Dr. Glenn Gould, Dr. Leslie Ellestad, Dr. Peggy Aufricht, Dr. Bill Hall (Medical Director), Dr. June Bergman (Chair), Dr. Remo Di Palma , Dr. Elaine Bland (Vice Chair), Dr. Dennis Fundytus, Dr. Dennis Hayes, Dr. Roger Thomas, Dr. Mohammed Abdel-Hafez

How we work



The Calgary Foothills Primary Care Network's governance model is a joint venture between AHS – Calgary and the Foothills Primary Care Physician Corporation. The six members of the Calgary Foothills Primary Care Network board are drawn three from the Foothills Primary Care Physician Corporation Board and three from AHS – Calgary. This board is responsible for ensuring the sustainability and financial health of the organization, as well as overseeing the development and execution of a long term organizational plan.

The nine members of the Foothills Primary Care Physician Corporation board represent the interests of physician members, oversee the quality of care, set strategic priorities, and regularly monitor and review PCN programs to ensure that the organization's mission, goals, and objectives are being met.

THE CALGARY FOOTHILLS PRIMARY CARE NETWORK

In addition to the two boards, the Calgary Foothills Primary Care Network operates each of its programs under the direction of Medical Leads. In 2009, they were:

- After Hours Care Program / Dr. Sandra Goranson
- Chronic Disease Management Program / Dr. Rick Ward
- Information Technology & Management Program / Dr. Norman Yee
- In-Hospital Care Program / Dr. Sarb Grewel
- Mental Health Program / Dr. Mark Joyce
- Obstetrical Care Program / Dr. Linda Slocombe
- Population Health Program / Dr. Karen Seigel
- Seniors Care Program / Dr. Marie Patton

Calgary Foothills Primary Care Network Board of Directors (left to right)
Dr. June Bergman, Dr. Elaine Bland, Laurie Blahitka, Pam Brown [missing]

Our programs

The Calgary Foothills Primary Care Network's vision is: **To develop a strong and integrated system of primary care services for patients within the Calgary Foothills PCN (CFPCN).**

Primary care is usually the first contact point for patients in the health care system – the point where they receive consistent and continuous care, often provided by a family physician. Family physicians are leaders in primary care as they assess incoming patients, recommend and monitor treatment, and call on the resources of other specialists and health care providers. The focus of a Primary Care Network is on patients accessing the right care, from the right professional, at the right time.

Delivering the best possible primary care requires programs that fit the needs of the people we serve. The Calgary Foothills Primary Care Network's "catchment area" is northwest Calgary and Cochrane and the programs we develop and administer are working to address this region's health priorities and concerns.

By bringing physicians and other primary health care providers together, we are able to achieve efficiencies, more clearly identify and serve patient needs, as well as cooperate on special programs. The CFPCN operates in partnership with Alberta Health Services.

1 AFTER HOURS CARE PROGRAM

Created in 2007, the goal of the After Hours Care program is to increase access to primary care outside of regular physicians' office hours. The After Hours Clinic is open evenings, weekends, and on statutory holidays for both patients of member physicians as well as for those who do not have a family doctor (unattached patients). Patients access the After Hours Clinic either by phoning Health Link, who assess if referral to the clinic is appropriate, or by direct referral from their family physician. The patient is booked an appointment that evening and once they have been seen, staff fax all visit and treatment information to the family physician the next day.

Cochrane physicians have an after hours call schedule as well as extended office hours for patients residing in Cochrane.

The After Hours Clinic currently sees between 6,000 – 7,000 patients per year. A recent survey of patients who used this service indicated that 19% of them would have visited an emergency department if the After Hours Clinic had not been available. 98% of the respondents reported being satisfied or very satisfied with their clinic experience.

Patients benefit through improved access to after hours medical services. Both family doctors and their patients benefit from the improved communication between the regular family physician and the physician providing after hours care.

2 CHRONIC DISEASE MANAGEMENT PROGRAM

A multidisciplinary team approach is central to the Chronic Disease Management (CDM) program, where family physicians, nurses, diabetic educators, dietitians, respiratory educators, and pharmacists all contribute to the ongoing support of patients with chronic health conditions such as diabetes, hypertension, chronic obstructive pulmonary disease (COPD), and asthma. Multidisciplinary team members work alongside family physicians in their offices. This complementary approach improves linkages between care teams as well as encourages greater patient access to the services most pertinent to their chronic condition.

Education and training in self management skills for people with chronic disease are offered in collaboration with AHS Living Well programs. Free group sessions such as Explain Pain, Understanding Diabetes, Food and Mood, etc. are held at our locations.

This program's Pain Management Group works in partnership with the Calgary Chronic Pain Centre to provide access for patients with non-complex neuro-musculoskeletal chronic pain at the CFPCN's Pain Management Clinic.

Member physicians may also consult a Chronic Pain specialist through the Tele-Chronic Pain Service, where physicians can discuss patient medications, diagnosis, and difficult/persistent health related issues over the phone.

Patients benefit from greater access to chronic disease services as well as from the support for self-management of their conditions. Physicians benefit by being able to integrate multidisciplinary support into their practices and by being able to offer more care options. Both groups benefit from the improved continuity of care and communication between chronic disease health care professionals and family physicians.

3 IN-HOSPITAL CARE PROGRAM

When a patient enters the hospital they are no longer in a primary care setting but rather an acute care one. The CFPCN's In-Hospital Care program focuses on strengthening communication and continuity of care as patients of CFPCN member physicians transition between these two settings.

This program works through a sub-group of CFPCN physicians who are available on a rotational basis to provide medical care for up to 36 patients at Foothills Medical Centre. In addition, two registered nurses coordinate the communication between family practice physicians and the hospital, facilitating communication and transfers of health record information, reconciliations of medications, and early follow-up for patients after discharge from the hospital.

The goal of the In-Hospital Care program is to improve patient safety by closing the communication gaps between acute care and community care.

4 MENTAL HEALTH PROGRAM

Integrating mental health care into the family practice setting helps the CFPCN increase accessibility to mental health services for member physicians and their patients.

Behavioural Health Consultants (BHCs) are available to address a wide range of mental health concerns with the goals of early identification, quick resolution, long-term prevention, and health promotion. BHCs work alongside family physicians and their teams in the family practice setting and are trained to help patients address mental health and lifestyle issues.

Education about mental health at the community level is also an important facet of the CFPCN's Mental Health programming. Health education classes for patients of physician members cover stress management and depression, providing basic information about each condition, available community resources and treatment options, and self-management skills.

Tele-psychiatry is another initiative established by the Mental Health program, which offers brief phone consultations with a psychiatrist for family physicians seeking guidance on specific patient issues.

Patients benefit from the improved communication and continuity of care between family physicians and mental health professionals, as well as improved access to mental health services within a familiar environment – their family doctor's office.

5 OBSTETRICAL CARE PROGRAM

The vision for the CFPCN's Obstetrical Care program is to ensure northwest Calgary and Cochrane women have timely and consistent access to low risk maternity services by developing an innovative, attractive model of care and support for the woman and her family, both during and after her pregnancy and delivery.

Four obstetrics groups work together at the Riley Park Maternity Clinic, which is located at 130, 1402 - 8th Avenue N.W. They provide low-risk obstetrical care to women who want to deliver at Foothills Medical Centre. The clinic is comprised of member physicians, registered nursing staff, and clerical support. It offers community resources which include access to a lactation consultant, a mental health consultant, and an obstetrician. The family physician and his/her patients may choose from one of two care models: 1) early referral, where patient care is transferred to the maternity clinic at an early stage in the pregnancy; or 2) a shared care model, where the family physician and the maternity clinic work together throughout the patient's pregnancy, transferring care to the clinic just prior to delivery.

The Riley Park Maternity Clinic currently sees an average of more than 3000 patients per month, an increase of 20% over the previous year. The clinic physicians also deliver an average of 250-300 babies each month.

The comprehensive nature of the obstetrical services offered makes it easier for patients to access what they require, while the improved communication with the family physician contributes to a high level of continuity of care for the patient.

6 CLINIC INNOVATIONS PROGRAM

The CFPCN provides practical strategies for helping family physicians run their offices efficiently and cost-effectively. This is especially important in an environment where rapidly rising expenses and human resource constraints create obstacles to physicians wishing to stay in family practice.

The Calgary Foothills PCN holds regular health education nights for physicians and their staff. Topics include key Calgary Foothills PCN and Alberta Health Services - Calgary programs and services, updated clinical practice guidelines, and team building activities.

The CFPCN provides the following supports to member physicians in order to help retain existing family physicians and attract new physicians to the field. The Continuity and Communications Fee compensates member physicians for time they invest to stay current on CFPCN activities and initiatives. The Multidisciplinary Team Fee is available on an annual basis for physicians working with multidisciplinary teams and supports communication through regular team meetings. Finally, the Office Access Support Fee is designed to compensate physicians for time away from their active family practices for holidays or education opportunities. This support enables members to take time to rejuvenate themselves, while continuing to offer uninterrupted care for the patients within their practice.

Calgary Foothills Primary Care Centre – Crowfoot (Unattached Patient Clinic)

This clinic provides temporary care to patients in northwest Calgary and Cochrane who do not have a family doctor. Patients are accepted from any AHS health care setting (e.g. hospital, outpatient clinics, emergency departments, home care, etc.) or patients may self refer.

The clinic provides a facilitated entry point for new physicians wishing to establish a family practice. Once the physician's practice is full they move out into the community, and may move to a PCN managed clinic, to an opportunity in a physician member's office, or to another location of their choice.

PCN Managed Clinics

Riley Park Family Medicine Clinic is a PCN managed clinic providing a fully equipped and staffed setting for family physicians. Both the Unattached Patient Clinic and the Riley Park Family Medicine Clinic optimize the use of multidisiciplinary teams and help increase the capacity of primary care for the population.

7 POPULATION HEALTH PROGRAM

Health promotion, prevention of injury and illness, and improvement of screening rates are the multiple goals of the CFPCN's Population Health program. By supporting member physicians in interacting effectively with their patients, a more accurate understanding of health needs is achieved, enabling specific programs to be developed to target them.

A cervical screening program is being run in partnership with the Alberta Cervical Cancer Screening program, identifying under screened women and encouraging them to book PAP test appointments with their family doctor. Those women who do not have a family doctor are offered an appointment at the Calgary Foothills Primary Care Centre (Unattached Patient Clinic).

The Walking program is a free exercise initiative designed to assist anyone who would benefit from regular walking. Peer-led sessions are conducted year round in both Calgary and Cochrane to help promote healthy lifestyles and active living within a safe and social environment.

The Tobacco Cessation program provides free group classes to patients of member physicians and combines educational information with the tools necessary to successfully quit smoking.

TrymGym is offered to CFPCN patients in partnership with the University of Calgary. This eight-week accredited weight management program combines behaviour change, nutrition education, and physical activity to help participants make healthy lifestyle changes. Patients of member physicians receive a subsidy to help offset the cost when they enroll.

"Ask a Dietitian" is a free group appointment for patients interested in the opportunity to meet with a registered dietitian who answers individual nutrition questions.

The Web Registry is a pan-PCN database designed to link patients without a family doctor with a doctor looking to establish or expand a practice. Health information collected assists our PCN in developing appropriate health programs to meet the needs of our patient population.

8 SENIORS HEALTH PROGRAM

Improving coordination and integration of primary care with services for seniors and supporting family physicians as they care for aging patient populations are the objectives of the CFPCN's Seniors Health program. This program is laying the foundation for seamless care and healthy aging and is moving towards integrating multidisciplinary teams for seniors in primary care.

The Foothills Long Term Care On-Call Group cares for patients of the group's physicians in 27 different long-term care facilities across Calgary. A total of 34 network physicians participate in the on-call group, providing after hours coverage on weekdays and weekends for patients who reside in long-term care facilities.

At the Bethany Care Society long-term care facility in Cochrane, a Nurse Practitioner is available to assist physician members who provide care to residents living there. The Nurse Practitioner role is designed to increase access to primary health care for residents, increase communication between physicians and family members, and improve the coordination of primary health care services with long term care. The importance of health promotion, illness and injury prevention, chronic disease management, and treatment of acute illness are also emphasized.

Patients benefit from the improved access to care in their community and improved quality of care in long term facilities.

9 INFORMATION TECHNOLOGY PROGRAM

Calgary Foothills PCN will support clinics with IT processes. This includes supporting each clinic through the process of completing a Privacy Impact Assessment (PIA) and Operational Readiness Assessment (ORA). The PCN is also piloting projects in data exchange and data capture, and is supporting moving clinics from paper records to EMRs (Electronic Medical Records).

The Panel Project underway at the PCN will support physicians in generating their own practice-specific population health data, in understanding that data, and in planning care based on the findings. Administrative support, data analysis, and screening tools will be available to assist in quality improvement activities.

Financial statements

Auditors' Report

July 16, 2009

To the Members of the Board of Directors of Calgary Foothills Primary Care Network

We are pleased to present the results of our audit of the Statement of Financial Position of the Calgary Foothills Primary Care Network ("CFPCN" or the "Organization") as of March 31,2009 and the Statements of Operations, Changes in Net Assets, and Cash Flows and the Schedules of Capital Assets and Expenses by Object for the year then ended (the "Financial Information").

This report to the Board summarizes the terms of our engagement, the issues of audit significance discussed with management, the status of our final procedures, and provides the communications required by our professional standards.

Our audit was designed to express an opinion on the Financial Information of CFPCN as at March 31, 2009 and for the year then ended. In planning the audit we held discussions with management, considered current and emerging business risks, performed an assessment of risks that could materially affect the Financial Information, and aligned our audit procedures accordingly. We received the full support and assistance of CFPCN's personnel in conducting our audit.

This report is intended solely for the use of the Board of Directors and management, and is not intended to be and should not be used by anyone other than these specified parties. We disclaim any responsibility to any third party who may rely on it. Further, this report is a by-product of our audit of the March 31, 2009 Financial Information and indicates matters identified during the course of our audit. Our audit did not necessarily identify all matters that may be of interest to the Board in fulfilling its responsibilities.

We appreciate this opportunity to meet with you to discuss the contents of this report and answer any questions you may have about these or any other audit-related matters.

Very truly yours,

Ernst & Young LLP

GREG RODYCH, PARTNER*
(403) 206-5022

* Services provided through Greg Rodych Professional Corporation, Partner

Statement of Operations

	BUDGET	ACTUAL	ACTUAL
	12 MONTHS ENDED MAR 31, 2009	12 MONTHS ENDED MAR 31, 2009	12 MONTHS ENDED MAR 31, 2008
	UNAUDITED	AUDITED	AUDITED
Revenue			
Per capita funding brought into revenue	$ 8,800,412	**$ 9,922,866**	$ 7,473,838
Capacity building grand brought into revenue	1,259,336	**1,259,336**	30,579
Specialist linkages grant	–	**–**	–
Pharmacist project grant	–	**–**	–
Interest and investment income	–	**91,634**	175,659
Amortization of capital contributions	–	**–**	–
FY 2008 surplus	3,253,149	**2,004,062**	–
Projected 2009 revenues	994,188	**1,176,357**	444,536
Other – (specify/list other income)	–	**–**	–
Other – (specify/list other income)	–	**–**	–
Revenue total	14,307,085	**14,454,255**	8,124,612
Expenses			
Obstetrics	1,573,710	**2,314,454**	1,012,878
Chronic Disease Management	3,042,526	**3,289,442**	1,247,792
After Hours Care	1,195,155	**1,220,955**	1,107,438
Mental Health	755,529	**430,706**	196,563
Population Health	407,062	**103,393**	35,992
In Hospital Care	700,594	**671,950**	702,105
Seniors Health	556,890	**442,056**	149,810
Office Supports	3,732,745	**3,037,508**	1,829,680
Expenses for priority initiatives	11,964,211	**11,510,465**	6,282,258
Evaluation	120,900	**102,022**	25,000
PCN administrative lead	127,308	**186,017**	133,820
Other management	666,960	**278,226**	177,530
Administration	1,350,331	**1,035,146**	885,809
Information technology	77,376	**74,389**	–
Support services	–	**–**	–
Amortization	–	**–**	–
Miscellaneous expenses	–	**–**	–
Expenses for central allocations	2,342,875	**1,675,799**	1,222,159
Total expenses	14,307,086	**13,186,263**	7,504,417
Revenue less expenses	$ –	**$ 1,267,992**	$ 620,195
Memo 1: per capita payments received	10,059,748	**11,193,975**	3,360,225
Memo 2: cbg payments received	–	**–**	629,668

Schedule of Expenses by Payment Type

	BUDGET 12 MONTHS ENDED MAR 31, 2009 UNAUDITED	ACTUAL 12 MONTHS ENDED MAR 31, 2009 AUDITED	ACTUAL 12 MONTHS ENDED MAR 31, 2008 AUDITED
Physicians: clinical	$ 6,641,823	**$ 6,522,739**	$ 1,810,575
Physicians: administrative	584,864	**568,388**	237,291
Physicians: other	–	**–**	2,007,400
Physicians subtotal	7,226,687	**7,091,128**	4,115,266
(RHA)	554,050	**559,680**	–
Non-physician direct care providers	2,183,450	**2,094,276**	881,841
Other expenses	4,342,899	**3,441,180**	2,507,310
Miscelaneous expenses	–	**–**	–
Total expenses	$ 14,307,086	**$ 13,186,263**	$ 7,504,417

Summary of Financial Position

	ACTUAL AS AT MAR 31, 2009 AUDITED	ACTUAL AS AT MAR 31, 2008 AUDITED
Assets		
Current asset – cash	**$ 2,010,538**	$ 961,644
Current asset – investments	**1,767,851**	3,200,000
Current asset – accounts receivable	**143,832**	–
Current asset – prepaid expenses	**105,565**	–
Current asset – deposits	**2,200**	166,639
	4,029,986	4,328,283
Capital assets	**–**	–
Total assets	**4,328,283**	6,780,039
Liabilities		
Current liabilities – deferred revenue	**515,315**	2,507,604
Current liabilities – unamortized capital contributions	**–**	–
Current liabilities – accounts payable	**1,501,133**	1,075,134
Current liabilities – other (specify)	**–**	–
	2,016,448	3,582,738
Non-current liabilities – deferred revenue	**–**	–
Non-current liabilities – unamortized capital contributions	**–**	–
Non-current liabilities – other (specify)	**–**	–
Total liabilities	**2,016,448**	3,582,738
Closing costs reserve	**788,212**	
Total liabilities and closing costs reserve	**2,804,660**	3,582,738
Net assets	**$ 1,225,325**	$ 745,545

Notes to Financial Statements

1) Authority, purpose and operations

The Calgary Foothills Primary Care Network (the "PCN") was established on August 1, 2006

The PCN is a joint venture governed equally by 1219453 Alberta Ltd. Not for Profit Corporation and Alberta Health Services – Calgary Zone, and provides comprehensive primary care services to residents within the PCN's geographical area in accordance within the terms of the Primary Care Initiative Committee (PCIC) approved Business Plan and PCIC approved amendments.

2) Significant accounting policies and reporting practices

Basis of presentation

The financial statements have been prepared in accordance with the reporting guidelines of the PCIC.

These financial statements use the deferral method, key elements of which are:

- Unrestricted contributions are recognized as revenue in the year receivable
- Restricted non-capital contributions are deferred and recognized as revenue in the year in which the related expenses are incurred.
- All other revenue is recognized as unrestricted / restricted

Revenue received from Alberta Health and Wellness

All revenue received from Alberta Health and Wellness, whether designated as restricted or unrestricted is only to be expensed in accordance with the PCN's approved business plan, addendums and amendments thereon.

3) Closing costs reserve

The Closing Costs Reserve included in the Statement of Financial Position (Table 2) includes estimated severance, leasehold and lease obligation costs due on wind-up of the PCN. This is a Primary Care Initiative Committee (PCIC) requirement.

4) Budget amounts

The budgeted amounts for 2008 – 2009 included in the financial statements have not been audited.

5) Approval of financial statements

These financial statements have been approved by the PCN's Governance Committee.

Corporate information

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