# Programs & Services Guide

# Guide overview

The CWC PCN designs and implements programs and services that link with community-based services and support physician members to build and sustain Patient's Medical Homes (PMHs).

This guide is your comprehensive source of information on all the PCN's programs and services with concise summaries, eligibility and access details, and patient information and hand-outs where applicable. Program eligibility is based on membership type; membership types are summarized and illustrated in the graphics below.

Programs and services are presented by priority area and program type:

### Patient's Medical Home

- **Mental Health Program,** which includes initial patient consultation on support needs, psychotherapy/counselling, and social work
- **Patient Panel Program** for panel management and Community Information Integration/Central Patient Attachment Registry (CII/CPAR)
- **Patient Screening and Chronic Disease Management Program,** which includes proactive outreach and screening, and chronic disease management

### Community Services, Transitions, and Integration

- **Community Services** such as Senior Services, Dietitian Program, Physiotherapy Program, and the Access Appointment Service
- **Community Services (external)** such as Prescription to Get Active, 24-hour blood pressure monitoring, and Specialist Link

### Member Services & Engagement

- **CME & PD,** which includes free educational opportunities
- **Physician Engagement Program,** which includes Member Services, focus groups, interviews, and other engagement opportunities
- **Practice Support Program,** which includes UpToDate, Lexidrug, and more

You can quickly navigate to specific program areas through the linked table of contents and links in the program information back to the table of contents.

The CWC PCN's membership model provides many services to all membership types. PMH supports are for members who commit to building PMHs using EMR data to inform patient care decisions for groups of patients. Program and service eligibility is clearly indicated throughout the guide.

**Membership types**

| | |
|---|---|
| A | **Associate** membership: For physicians who cannot participate in PMH activities with the CWC PCN due to the nature of their practice. |
| S | **Standard** membership: For physicians who are not quite ready to build PMHs or are not presently interested in CWC PCN support with completing PMH activities. |
| E | **Enhanced** membership: For physicians interested in working with support from the CWC PCN on their own PMH improvement goals for their panel of patients. |
| C | **Comprehensive** membership: For groups of two or more physicians interested in working together with support from the CWC PCN on shared PMH improvement goals for their panels of patients. |
| P | **Pediatricians** have access to programs and services appropriate for their practice. |

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# Patient’s Medical Home

*Supporting members and patients with integrated team-based care, chronic disease management and screening, and mental health support.*

# PMH overview

Using a population-based approach, Patient's Medical Home (PMH) teams support members and patients with integrated team-based care, chronic disease management and screening, and mental health support.

PMH teams collaborate with physicians and use a data-driven approach to identify and implement clinic processes that promote patient care and management. They leverage population-based principles, concepts, and thinking to support physicians in the development of their PMHs.

PMH programs and services are provided through the Mental Health Program, Patient Panel Program, and Patient Screening and Chronic Disease Management Program.

### Mental Health Program

- Centralized mental health referrals
- Psychotherapy
- Social Work

### Patient Panel Program

- Panel management and CII/CPAR

### Patient Screening and Chronic Disease Management Program

- Chronic disease management
- Proactive outreach and screening

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# Your PMH team | How we support you and your patients

*Regulated Health Professionals*

*Patient Medical Home Coordinators (PMHCs)*

## Primary Care Registered Nurses (PCRNs)

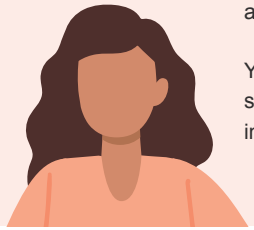
**PCRNs work with patients to assist them in managing their health and wellness.** They can provide patient education, preventative care, lifestyle coaching, and self-management support.

Your PCRN will work closely with you to discuss patient concerns and update you on appointment outcomes. Your PCC can support you in booking patient appointments with your PCRN.

## Health Information Coordinators (HICs)

**HICs can assist you with data-focused work,** including patient identification for quality improvement projects, support for EMR processes and data management requests, and more.

Your HIC can facilitate chronic disease screening projects and track their progress in an online tool.



**PCRPs provide goal-oriented counselling and psychotherapy sessions.** Patients will learn tools and strategies for creating change, building resiliency, and coping with a variety of mental health conditions.

Your PCRP will communicate with you regularly to ensure you are informed on patient progress and goals. Your patients can access your PCRP by referral using the mental health referral form.

## Primary Care Registered Psychologists (PCRPs)

**PCCs support patient-focused work,** including outreach, patient appointment booking and coordination, chart updates, and more.

Working alongside the HIC, your PCC supports quality improvement projects by contacting patients due for screening and chronic disease management appointments.

## Patient Care Coordinators (PCCs)

# Centralized mental health referrals

MENTAL HEALTH PROGRAM

Members can refer their patients to the Mental Health Program's centralized mental health referral service for a phone consultation with a Primary Care Registered Psychologist (PCRP) to determine support needs.

The PCRP will work with the patient to help them decide the best care pathway for their unique needs.

Depending on the patient's needs, interest/readiness, preference, and circumstances, they may be referred to psychotherapy with a **Primary Care Registered Psychologist** (patients of Enhanced or Comprehensive members only) or to **a mental health service** in the community.

All patients referred to the Mental Health Program will be offered **self-management resources** following their initial consultation with a PCRP.

| MEMBER BENEFIT | |
|---|---|
| P S E C | |
| REFERRAL | Referral form |
| CONTACT | Physician Liaison |
| FOR PHYSICIANS AND PROVIDERS | |
| Impact | |
| How to refer | |
| FOR PATIENTS | |
| Information for patients | |
| APPOINTMENT DETAILS | |
| WAIT TIME | Seven business days for initial call to set up an appointment |
| LENGTH | 30 - 50 minutes |
| LIMIT | Short-term (no fixed limit) |
| TYPE | Virtual (phone call, video call) |

## Eligibility

Pediatricians, Standard, Enhanced, and Comprehensive members can refer patients to our Mental Health Program's centralized mental health referral service.

Referrals can be made for reasons including, but not limited to:

- Addictions
- Anxiety
- Depression
- Grief/loss
- Health concerns
- Life transitions
- Personal growth
- Relationships
- Trauma

A full list of referral reasons can be found on the Referral Form - Mental Health in your EMR.

## Impact

Patients will work with a Primary Care Registered Psychologist to identify their goals. Depending on the individual, patients may gain tools through treatment for creating change, building resiliency, or coping. With their physician, patients can identify the focus for their treatment on the referral form.

## How to refer

Please complete the Referral Form - Mental Health found in your clinic's EMR to refer patients. This form is best filled out with the patient, ensuring they clearly understand the reasons for their referral.

If this referral form is not yet in your EMR, you can download the form from cwcpcndocs.com and upload it to your EMR files.

Alternately, or if your clinic does not use an EMR, this form can be faxed to 855.966.4102.

## Information for patients

Within seven business days of their referral, the referred patient will receive a call from a Patient Care Coordinator to book a consultation appointment with a Primary Care Registered Psychologist (PCRP). During the appointment, the PCRP will complete a questionnaire (i.e., CORE-10) with the patient to help understand the nature of their distress, if appropriate, and work with the patient to identify their goals.

After this, the PCRP will provide the patient with self-management resources.

If the patient is interested in, and ready for, additional care, the PCRP will refer them to services in our community (e.g., Community Connect YYC, Calgary Counselling Centre).

Enhanced and Comprehensive members' patients may also be referred to psychotherapy with a Primary Care Registered Psychologist if the patient prefers.

*In case of emergency, go to the nearest emergency department or hospital, or call 911 or the Distress Centre phone line at 403.266.HELP (403.266.4357).*

# Mental Health Program patient handout

Your doctor has **referred you** to the Calgary West Central Primary Care Network (CWC PCN) **Mental Health Program** to help you find mental health support based on the reason for your referral.

You will **receive a phone call** to book a consultation appointment with a Registered Psychologist at the CWC PCN to discuss your care needs in greater detail. Together, you will determine the most suitable approach for your situation, and the CWC PCN will provide you with resources or a referral accordingly.

This service is at **no cost** to you.

| CONTACT | |
|---|---|
| WEBSITE | cwcpcn.com |
| PHONE | 403.251.2207 |
| **LOCATION DETAILS** | |
| HOURS | Monday to Friday<br>8:30 a.m. - 4:30 p.m. |
| LOCATION | Virtual |
| ACCESSIBILITY | Varied |
| **APPOINTMENT DETAILS** | |
| COST | Varied |
| WAIT TIME | The CWC PCN will call to schedule an appointment within seven business days |
| TYPE | One-on-one |
| LENGTH | Varied |
| What you should know before your appointment | |
| Cancellation policy | |

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## What you should know before your appointment

Your first phone call will come from our Patient Care Coordinator; during this call, you will **schedule time** with one of the CWC PCN's Registered Psychologists for a **brief initial** consultation on your needs.

Your scheduled **initial** consultation **call** will last approximately 30 minutes. During this call, you and the Registered Psychologist will discuss your needs and hopes for psychological support. You may complete an assessment tool known as the CORE-10. The Registered Psychologist will explain **care options** (including CWC PCN services, community resources and agencies, and self-management resources) to you, including no-cost and sliding-scale fee services. Together, you and the Registered Psychologist will determine the most **suitable service for you.**

After your initial consultation, the Registered Psychologist will provide you with **self-management tools.**

All **information** discussed during these calls **is confidential.** The only **limits to that** confidentiality are:

1. A consult report will be sent to the referring physician to inform them of the plan of action/support that you and the Registered Psychologist agree upon.
2. If at any point during the conversation the Registered Psychologist has cause to be concerned about someone's safety, they are required by law to report their concerns to the appropriate authorities.

## Cancellation policy

Please contact the CWC PCN at 403.251.2207 **as soon as possible** to cancel your appointment.

# Psychotherapy

MENTAL HEALTH PROGRAM

The CWC PCN's Primary Care Registered Psychologists (PCRPs) are Registered Psychologists in good standing with the College of Alberta Psychologists.

PCRPs offer short-term counselling services to members' patients **free of cost.** They will provide patients with **30 - 50 minute psychotherapy sessions** and address a **broad scope of mental health needs.** All patients referred to the Mental Health Program will also be offered **self-management resources.**

| MEMBER BENEFIT | |
|---|---|
| E C | |
| REFERRAL | Referral form |
| CONTACT | Physician Liaison |
| FOR PHYSICIANS AND PROVIDERS | |
| Impact | |
| How to refer | |
| ROLE PROFILE | |
| Primary Care Registered Psychologist | |
| FOR PATIENTS | |
| Information for patients | |
| APPOINTMENT DETAILS | |
| WAIT TIME | The CWC PCN will call to schedule an appointment within seven business days. |
| LENGTH | 30 - 50 minutes |
| LIMIT | Short-term (no fixed limit) |
| TYPE | Virtual (phone call, video call) |

## Eligibility

Enhanced and Comprehensive members' patients can be referred to a PCRP. The program accepts both minor (typically 12-plus years old) and adult patients.

Referrals can be made for reasons including, but not limited to:

- Addictions
- Anxiety
- Depression
- Grief/loss
- Health concerns
- Life transitions
- Personal growth
- Relationships
- Trauma

A full list of referral reasons can be found on the referral form in your clinic's EMR.

### Impact

Patients will work with their PCRP to identify their goals. Depending on the individual, through treatment, patients may gain tools for creating change, building resiliency, and coping. With their physician, patients can identify the focus for their treatment on the referral form.

### How to refer

Enhanced and Comprehensive members' patients can be referred to a PCRP. The program accepts both minor (typically 12 years old and up) and adult patients.

For pediatric patients, a direct referral to The Summit — for patients living in west Calgary — or Eastside Community Mental Health Services — for patients living in east Calgary — is recommended.

Patients are referred using the Primary Care Referral Form - Mental Health. This form is best filled out with the patient, ensuring they clearly understand the reasons for their referral.

### Information for patients

At their first encounter, the PCRP will review informed consent and release forms with the patient.

Mental health services take place virtually by video call or telephone. Patients will work with their PCRP to determine how often meetings will occur. Sessions may range from 30 to 50 minutes.

In case of emergency, go to the nearest emergency department or hospital or call 911 or the Distress Centre phone line at 403.266.HELP (403.266.4357).

# Social Work

MENTAL HEALTH PROGRAM

The CWC PCN Social Work team is available to **support patients of all ages** — from seniors to children and their families — **access support and navigate the health system.** Referrals are accepted for a variety of concerns that may impact the patient's quality of life, living conditions, or healthcare access.

The Social Workers meet with patients as often as required to determine their needs and refer them to appropriate community resources for ongoing assistance. **Sessions are conducted in the Primary Care Centre, by phone, video, or in the patient's home depending on their needs.**

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| REFERRAL | Referral form |
| CONTACT | Physician Liaison |
| **FOR PHYSICIANS AND PROVIDERS** | |
| Eligibility | |
| Impact | |
| How to refer | |
| **ROLE PROFILE** | |
| Social Worker | |
| **FOR PATIENTS** | |
| Information for patients | |
| **LOCATION DETAILS** | |
| ADDRESS | Primary Care Centre<br>5960 Centre St. S., Calgary<br>*Virtual, home, and community visits available |
| HOURS | Monday to Friday<br>8:30 a.m. - 4:30 p.m.<br>*(non-weekend) outside hours can be available in limited circumstances |
| **APPOINTMENT DETAILS** | |
| WAIT TIME | Varied |
| LENGTH | Varied |
| LIMIT | Varied (short-term support) |
| TYPE | In person, video, or phone |

## Eligibility

Patients of **all ages** who are attached to a CWC PCN physician member.

## Impact

The Social Work team plays a critical role in helping patients and families address the impact of illness, complex health issues, and life stressors by facilitating access to supports and resources that aid in patient well-being.

## How to refer

CWC Primary Care Centre referral form.

## Information for patients

A patient's initial appointment with a CWC PCN Social Worker includes an **initial assessment** of **approximately 60 minutes,** or longer if a home visit. If any services or supports are identified at the time, the details of the support will be shared as part of the conclusion of the assessment. If any additional referrals, support, or follow-up is required, the patient and the Social Worker will agree on a plan moving forward (e.g., how often the Social Worker will check in, what referrals need to be made, any follow-up appointments scheduled, etc.).

**Please note** Social Worker services at the CWC PCN are meant as **short-term** supports to help link patients with community supports and agencies — **not** as long-term case managers. However, if a patient's needs are assessed as being more complex, the Social Worker may remain involved on a medium-term basis while a longer-term support is set up.

All information disclosed during the discussions with Social Workers is **confidential.** The only **limits to that confidentiality** are:

1. A consult report will be sent to the referring physician to inform them of the plan of action/support that the patient and the Social Worker agree upon.
2. If the Social Worker needs to speak with any other agencies/support, they require the patient's written consent to disclose/collect information on the patient's behalf.
3. If at any point during the conversation the Social Worker has cause to be concerned about someone's safety, they are required by law to report their concerns to the appropriate authorities.

# Social Work patient handout

Your doctor has **referred you to** a Calgary West Central Primary Care Network (CWC PCN) **Social Worker** to assist you in accessing support and navigating the health care system.

You will **receive a phone call** from the CWC PCN to book your appointment. Sessions are conducted in the clinic, by phone or video, or in your home.

This service is **free.**

| CONTACT | |
|---|---|
| WEBSITE | cwcpcn.com |
| PHONE | 403.686.0020 |
| **LOCATION DETAILS** | |
| HOURS | Monday to Friday<br>8:30 a.m. - 4:30 p.m.<br>*(non-weekend) outside hours can be available in limited circumstances |
| LOCATION | Primary Care Centre<br>5960 Centre St. S., Calgary<br>*Virtual, home, and community visits available. |
| ACCESSIBILITY | Free parking, seven-minute walk from Chinook Train Station. |
| **APPOINTMENT DETAILS** | |
| COST | Free |
| WAIT TIME | Varied |
| TYPE | One-on-one, family |
| LENGTH | Varied |
| What you should know before your appointment | |
| Cancellation policy | |

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## What you should know before your appointment

Your initial appointment with a CWC PCN Social Worker includes an **initial assessment** of **approximately 60 minutes,** or longer if a home visit. If any services or supports are identified at the time, the details of the support will be shared as part of the conclusion of the assessment. If any additional referrals, support, or follow-up is required, you and the Social Worker will agree on a plan moving forward (e.g., how often the Social Worker will check in, what referrals need to be made, any follow-up appointments scheduled, etc.).

**Please note** that the Social Worker services at the CWC PCN are meant as short-term supports to help link you with community supports and agencies — not as long-term case managers. However, if your needs are assessed as being more complex, the Social Worker may remain involved on a medium-term basis while a longer-term support is set up.

All **information disclosed** during the discussions with Social Workers **is confidential.** The only **limits to that confidentiality** are:

1. A consult report will be sent to the referring physician to inform them of the plan of action/support that you and the Social Worker agree upon.
2. If the Social Worker needs to speak with any other agencies/support, they require your written consent to disclose/collect information on your behalf.
3. If at any point during the conversation the Social Worker has cause to be concerned about someone's safety, they are required by law to report their concerns to the appropriate authorities.

## Cancellation policy

Please contact the Primary Care Centre at 403.686.0020 as soon as possible to cancel your appointment.

# Panel management and CII/CPAR

PATIENT PANEL PROGRAM

The Panel Support Program (PSP) **supports physician members with paneling and preparation for the Community Information Integration/Central Patient Attachment Registry** (CII/CPAR). Participation in the PSP supports the identification and formalization of clinic panel processes, a mutual understanding of clinic panel for efficient and effective team-based care, and navigation for registration with CII/CPAR.

Members participating in the PSP will be **supported by a Health Information Coordinator** (HIC) **and the Quality Improvement Consultant** for assistance documenting or developing panel processes.

The PSP has **three stages: panel identification, panel maintenance,** and **CII/CPAR.** The PSP will be tailored to a physician's practice and preferences. Panel work is at the direction of the physician, and any identified actions can be supported by the HIC.

Upon completion of the PSP's early stages, **physicians are sent a Discovery Report** to learn more about their panel breakdown and will be assisted in the CII/CPAR registration process.

| MEMBER BENEFIT | |
|---|---|
| P S E C | |
| TARGET POPULATION | All patient panels |
| CONTACT | Physician Liaison |
| **FOR PHYSICIANS AND PROVIDERS** | |
| Eligibility | |
| Impact | |
| How to enroll | |

## Eligibility

All members with a panel of patients are currently eligible. Participation in the PSP is the first step in working with your PMH team and a requirement for Enhanced and Comprehensive members. Members without a panel but who are eligible and interested in participating in CII to submit consult notes and/or encounter data can also request support for CII navigation and onboarding. Support will vary based on the needs of your practice.

Physicians must be able to provide remote EMR access for the HIC, as well as agree to meet and communicate with the team throughout the process as needed.

## Impact

Establishing a panel supports both relational and informational continuity, benefiting patient care. Continuity of care with a most responsible provider and their team benefits the patient, the clinic, and the healthcare system and is one of the 10 pillars of the PMH model.

Paneling and CII/CPAR support is tracked as part of the improvement goals that PMH teams support. Metrics include physician eligibility for the program, patient validation rates, and CII/CPAR eligibility.

## How to enroll

Interested physicians can reach out to their Physician Liaison to discuss participation in the PSP. To participate, the clinic must be able to grant remote EMR access.

# Chronic disease management

PATIENT SCREENING AND CHRONIC DISEASE MANAGEMENT

Our chronic disease management Primary Care Registered Nurses (PCRNs) work from home to **support patients in a flexible booking structure** where patients are seen any day their nurse is working. Appointments are primarily virtual, but in-person appointments are available depending on the patient's needs and preference.

PCRNs use their knowledge and skills to address a variety of patient concerns, including:

- Lifestyle modification
- Chronic disease management
- Smoking cessation
- Health education

These preventive health services provide patients with the tools, education, and support needed to better understand and self-manage their chronic diseases.

| MEMBER BENEFIT | |
|---|---|
| E C | |
| TARGET POPULATION | Patients of Enhanced and Comprehensive members. |
| AGE | All ages |
| REFERRAL | Through physician or PCRN |
| CONTACT | Physician Liaison |
| FOR PHYSICIANS AND PROVIDERS | |
| Impact | |
| How to refer | |
| ROLE PROFILE | |
| Primary Care Registered Nurse | |
| FOR PATIENTS | |
| Information for patients | |
| LOCATION DETAILS | |
| HOURS | Monday to Friday<br>8:30 a.m. - 4:30 p.m.<br>*Some 8 a.m. - 4 p.m. |
| APPOINTMENT DETAILS | |
| WAIT TIME | Varies (depending on PCRN) |
| LENGTH | Initial: 60 minutes (generally)<br>Follow-up: 30 minutes |
| LIMIT | No |
| TYPE | Primarily virtual (video call or telephone) and in person |

## Impact

Our nurses are trained in many areas related to chronic disease. Nurses have comprehensive education and/or certification in hypertension, heart health, diabetes, obesity and weight management, COPD, asthma, smoking cessation, various gastrointestinal issues, and many other conditions, including mental health concerns.

In addition to clinical knowledge, our nurses are all trained in HealthChange Methodology. This methodology allows our nurses to use their knowledge to support patients in making lifestyle and other changes toward their best health.

## How to refer

Physicians can contact their Patient Care Coordinator (PCC) to set up patient appointments with a nurse for chronic disease management. This can be done through tasks or other messaging within the EMR.

As well, nurses work directly with a PCC and a Health Information Coordinator, so physicians can consult this team to set goals for meeting clinical targets for certain types of patients.

This means that our Patient's Medical Home (PMH) team can actively call patients who have certain characteristics to book appointments with PMH team members or physicians themselves. This work allows clinics to practice more comprehensive preventative care.

## Information for patients

Any patient who has a health goal that they would like support with can be referred. More specifically, please refer those patients who struggle keeping up with clinical targets and those who have specific health goals.

# Chronic disease management patient handout

Your doctor has **referred you** to a Calgary West Central Primary Care Network (CWC PCN) **Primary Care Registered Nurse** to support you on your healthcare journey and help you manage your condition.

Your Primary Care Registered Nurse is a member of your doctor's care team and works closely with them to support patients as they work toward their health goals.

You will **receive a phone call** from the CWC PCN to book your appointment. You may elect to have your appointment virtually (via telephone or video call) or in person at your doctor's clinic.

This service is available at **no cost** to you.

| CONTACT | |
|---|---|
| WEBSITE | cwcpcn.com |
| PHONE | Your doctor's office |
| **LOCATION DETAILS** | |
| HOURS | Monday to Friday<br>8:30 a.m. - 4:30 p.m. |
| LOCATION | Virtual or in clinic |
| ACCESSIBILITY | N/A |
| **APPOINTMENT DETAILS** | |
| COST | Free |
| WAIT TIME | Varied |
| TYPE | One-on-one |
| LENGTH | Varied |
| Cancellation policy | |

## What you should know before your appointment

Your initial appointment with a CWC PCN Primary Care Registered Nurse will last **approximately 60 minutes.** Based on your scheduling phone call, this will take place virtually (phone or video call) or in person at your doctor's office.

During this meeting, you and your Primary Care Registered Nurse will discuss your healthcare journey, including your goals and any support you may need moving forward. Together, you will determine how often you will need to meet and what the focus of your appointments will be.

### Notes on video call appointments

During your scheduling phone call, you may be asked for consent to be registered in Pomelo. Pomelo is the CWC PCN's secure patient communications platform that Primary Care Registered Nurses use to conduct video appointments. The CWC PCN also uses Pomelo to send you secure messages and appointment reminders.

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If you consent, the CWC PCN will send you an invitation link to register for Pomelo.

You can unsubscribe from Pomelo notifications at any time.

## Cancellation policy

Please contact your doctor's office as soon as possible to cancel your appointment. This will allow your Primary Care Registered Nurse to see another patient.

# Proactive outreach and screening

PATIENT SCREENING AND CHRONIC DISEASE MANAGEMENT

Proactive outreach and preventative screening **support continuity of care** for patients at their PMH.

The PMH team supports the physician to **identify patient groups** that would benefit from proactive screening or chronic disease management:

- Health Information Coordinators (HICs) use EMR data to identify patient groups for quality improvement projects, identify screening maneuvers, and recommend screening projects for chronic disease management.
- Patient Care Coordinators (PCCs) are able to coordinate patient care through outreach for appointment scheduling, updating charts, and gathering hospital transfer information.

PMH teams **monitor progress** and **keep the physician informed about progress.**

| MEMBER BENEFIT | |
|---|---|
| E C | |
| TARGET POPULATION | Patients identified through a patient screening goal |
| AGE | Various |
| CONTACT | Health Information Coordinator |
| FOR PHYSICIANS AND PROVIDERS | |
| How to refer | |
| ROLE PROFILES | |
| Health Information Coordinator | |
| Patient Care Coordinator | |

## Eligibility

PMH teams work with Enhanced and Comprehensive physician members to improve patient care.

Patient's eligibility is determined by best practice guidelines and planned in collaboration between the physician and the PMH team.

## Impact

Proactive outreach and screening initiatives ensure patients at-risk of developing health conditions are identified and treated early. This early identification can assist in preventing negative health outcomes for patients.

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The use of EMR data allows for targeting screening initiatives, ensuring that patients receive care specific to their demographic and needs.

### How to refer

Enhanced and Comprehensive members interested in developing a screening goal to support their patients' and their medical home should reach out to their Health Information Coordinator to set up a PMH team meeting.

Standard physicians with a family practice panel who would like to participate should contact their Physician Liaison to discuss their membership type.

# Community Services, Transitions, and Integrations

*Cultivating partnerships that support the patient's journey from their PMH to community programs and back again.*

# CSTI overview

Through the Community Services, Transitions, and Integration (CSTI) priority area, the PCN's teams offer services to all members and cultivates partnerships that support the patient's journey from their Patient's Medical Home (PMH) to community programs and back again.

CSTI supports the alignment and integration of services between the PMH, the medical neighbourhood, and the healthcare system with programs and formal connections to external service providers. CSTI programs are designed to close gaps in care coordination and improve access and patient transitions across healthcare services.

Programs and formal connections are provided through Community Services and Transitions and Integration.

### Community Services

- Access Appointment Service
- Dietitian Program
- Physiotherapy Program
- RhoGAM/WinRho referral service
- Senior Services

### Community Services (external)

- 24-hour blood pressure monitoring
- Prescription to Get Active
- Specialist Link

*The CWC PCN is sharing this information to promote awareness about community resources and does not endorse or provide any guarantees related to these services.*

# Access Appointment Service

COMMUNITY SERVICES

The Primary Care Centre offers **enhanced access** with an Access Appointment Service for members' patients in need of medical care within 24 hours who are unable to obtain an appointment at their medical home. This service is also available to unattached patients within the PCN's geographic boundaries.

This referral service maintains informational continuity and provides an alternative to the walk-in system or a visit to the ED/urgent care for less urgent concerns. Patients are seen by fellow CWC PCN physician members, and the Primary Care Centre faxes a summary of the visit to their family physician after the appointment. It is intended as a temporary support of the Patient's Medical Home, and patients are not seen on a long-term or ongoing basis.

Services are available **by referral/appointment only.**

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| REFERRAL | Referral form |
| CONTACT | Physician Liaison |
| **FOR PHYSICIANS AND PROVIDERS** | |
| Eligibility | |
| Impact | |
| How to refer | |
| Inclusion-exclusion criteria (PDF) | |
| **FOR PATIENTS** | |
| Information for patients | |
| **LOCATION DETAILS** | |
| ADDRESS | Primary Care Centre<br>5960 Centre St. S., Calgary |
| HOURS | Monday to Friday<br>9 a.m. - 9 p.m.<br>Weekends and holidays<br>9 a.m. - 4 p.m. |
| **APPOINTMENT DETAILS** | |
| WAIT TIME | Within 24 hours |
| LENGTH | 15 minutes |
| TYPE | One-on-one, family |

## Eligibility

This service is available for patients with non-urgent care needs who need an appointment within 24 hours and are either a:

- Patient of a CWC PCN physician member
- Unattached patient living within the CWC PCN's geographic boundaries
- Patient of a non-CWC PCN physician referred via Rockyview General Hospital or Health Link's barrier-free access option

The barrier-free access option gives patients of urban PCNs the option of accessing any of the three participating PCN access clinics: the CWC PCN's Primary Care Centre, the Calgary Foothills PCN's Access 365 Clinic, and Mosaic PCN's ACCESS Clinic. The participating clinics can also offer referred patients a choice of the other two clinics if the initial clinic's location is inconvenient. The barrier-free access option is only available to patients who are triaged and deemed in need of care within 24 hours.

## Impact

Physician members have support from the PCN in meeting their CPSA requirement for continuity of care; members' patients are seen in a timely manner for urgent (but non-emergency) concerns; continuity of care for CWC PCN patients; cost-savings for acute care system when patients are redirected from an ER to the Primary Care Centre.

## How to refer

Physician members can refer their patients to the Primary Care Centre's appointment service via the CWC Primary Care Centre referral form.

Patients can also be directed to the service by calling Health Link at 811 if their physician's practice is closed.

The Primary Care Centre also receives several referral types from Rockyview General Hospital: ED Triage (non-urgent re-direct from the emergency department), ED Diagnostic Imaging Follow-Up, and ED Post-Discharge, as well as Enhanced Hospital Discharge referrals from all Calgary area hospitals. (ED Post-Discharge and Enhanced Hospital Discharge referrals direct unattached patients who are discharged from hospital to the Primary Care Centre for follow-up and/or attachment.)

Unattached patients referred to the Primary Care Centre are directed to the online patient web registry (albertafindadoctor.com) and provided an up-to-date list of physicians in the area accepting new patients.

## Information for patients

Services are available by referral and appointment only. A patient can contact Health Link at 811 to be referred to the Primary Care Centre, if appropriate, when their physician's clinic is closed.

- **Location:** Primary Care Centre, 5960 Centre St. S., Calgary
- **Accessibility:** Free parking, seven-minute walk from Chinook transit station
- **Appointment details:**
    - The patient should arrive 5 - 10 minutes early.
    - If the patient must cancel the appointment, they need to contact the Primary Care Centre at 403.249.9907.

# Access Appointment Service patient handout

Your doctor has **referred you to** the Calgary West Central Primary Care Network (CWC PCN) **Primary Care Centre** for your appointment. This service is for CWC PCN physician members' patients who are unable to obtain an appointment with their family doctor, or for patients who do not have a family doctor and live within the CWC PCN's geographic boundaries. This service can **only be accessed via referral** from your family doctor or **Health Link.**

This service provides an alternative to the walk-in system or a visit to the emergency department or urgent care. You will be **seen by a family doctor** and a **summary of your visit** will be faxed back to your family doctor after your appointment.

You will **be contacted by phone** by the CWC PCN Primary Care Centre to book your appointment.

This service is **available at no cost to you.**

| CONTACT | |
|---|---|
| WEBSITE | cwcpcn.com |
| PHONE | 403.249.9907 |
| **LOCATION DETAILS** | |
| HOURS | Monday to Friday<br>9 a.m. - 9 p.m.<br>Weekends and holidays<br>9 a.m. - 4 p.m. |
| LOCATION | Primary Care Centre<br>5960 Centre St. S., Calgary |
| ACCESSIBILITY | Free parking, seven-minute walk from Chinook Train Station. |
| **APPOINTMENT DETAILS** | |
| COST | Free |
| WAIT TIME | Within 24 hours |
| TYPE | One-on-one, family |
| LENGTH | 15 minutes |

## What you should know before your appointment

Services are available by referral/appointment only. Please arrive 5 - 10 minutes early.

## Cancellation policy

Please contact the Primary Care Centre at 403.249.9907 as soon as possible to cancel your appointment.

Primary Care Network
CALGARY WEST CENTRAL

# Dietitian Program

COMMUNITY SERVICES

The CWC PCN's Dietitian program provides eligible, referred patients a **one-on-one** appointment with a Primary Care Registered Dietitian to expertly assess their needs and determine the most appropriate type of care.

Patients are then connected to the **most appropriate type of care:**

- One-on-one Primary Care Registered Dietitian appointment(s) for nutritional counselling within the program
- Referral to an AHS or community-based service or provided self-management resources
- Referral to a Primary Care Registered Nurse (for patients of physicians with Enhanced or Comprehensive membership).

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| REFERRAL | Referral form |
| CONTACT | Physician Liaison |
| FOR PHYSICIANS AND PROVIDERS | |
| Impact | |
| How to refer | |
| ROLE PROFILE | |
| Primary Care Registered Dietitian | |
| FOR PATIENTS | |
| Information for patients | |
| APPOINTMENT DETAILS | |
| WAIT TIME | Three business days for initial call to set up an appointment. |
| LENGTH | 30 - 60 minutes |
| HOURS | Monday to Friday<br>8:30 a.m. - 4:30 p.m. |
| TYPE | Primarily virtual (video call, phone call) with in-person option |

**Eligibility**

This service is available for patients aged 10 and up who require nutritional counselling for one of the primary concerns below and are not eligible for coverage by other health payers and unable to pay for services out of pocket:

- Gastrointestinal health (irritable bowel syndrome, Crohn's disease, ulcerative colitis, and celiac disease)

- Liver health
- Kidney health

For nutritional counselling for obesity and weight management, cardiovascular health, or diabetes, refer patients to your Primary Care Registered Nurse (Enhanced and Comprehensive members), the Alberta Healthy Living Program's services, or Health Link Dietitian Service (patients can complete the self-referral form to be contacted by a Health Link Dietitian). Our PCN also developed a curated collection of free programs, classes, and workshops in the community for patients. You can use our Nutrition Resources Guide (with links to patient handouts) when referring outside of our Dietitian Program.

### Impact

Patients will have access to no-cost, one-on-one dietitian support, which can be cost-prohibitive for some, for gastrointestinal health, liver health, and liver health. The Primary Care Registered Dietitians will assist patients through nutrition counselling or referral to the most appropriate care based on their specific needs.

### How to refer

Please complete the *CWC PCN Dietitian Program Referral Form* found in your clinic's EMR to refer patients. If this referral form is not yet in your EMR, you can download the form and upload it to your EMR files. Alternatively, or if your clinic does not use an EMR, this form can be printed and faxed to 587.387.7264.

### Information for patients

Within three business days of referral, the referred patient will receive a call from the Program Coordinator to book the initial appointment with one of the Primary Care Registered Dietitians. During this appointment, the Primary Care Registered Dietitian will:

- Work with the patient to understand what success looks like to them
- Use their expertise to assess and determine the appropriate type of care
- Determine the patient's existing knowledge about nutrition and healthy eating
- Explore what influences health and diet e.g., environment, culture.

In initial or following appointments, the patient and Primary Care Registered Dietitian will work together to:

- Determine a care plan that works for the patient
- Make relevant referrals, as appropriate (internal and external)
- Provide support from a patient-centred approach to help the patient take control of their nutritional health and eliminate any overwhelming or negative feelings

# Dietitian Program patient handout

Your doctor has **referred you to** the Calgary West Central Primary Care Network (CWC PCN) **Dietitian Program** to help you determine appropriate and beneficial ways to promote healthy eating and diet based on the reason for your referral.

You will **receive a phone call** to book your initial, one-on-one appointment with a CWC PCN Primary Care Registered Dietitian so that you can discuss your needs in greater detail. Together, you will determine the most appropriate type of care for you going forward.

This service is **available at no cost to you.**

| CONTACT | |
|---|---|
| WEBSITE | cwcpcn.com |
| PHONE | 403.984.6533 |
| **APPOINTMENT DETAILS** | |
| COST | Free |
| WAIT TIME | Three business days for initial call to set up an appointment. |
| HOURS | Monday to Friday<br>8:30 a.m. - 4:30 p.m. |
| TYPE | Primarily virtual (video call, phone call) with in-person option |
| LENGTH | 30 - 60 minutes |

## What you should know before your appointment

Your first phone call will come from our Program Coordinator; during this call, you will **schedule time** with one of the CWC PCN's Primary Care Registered Dietitians.

Your scheduled **initial** consultation **call** will last approximately one hour. During this call, you and the Primary Care Registered Dietitian will discuss your needs and goals for dietitian support as it relates to your referral reason. The Primary Care Registered Dietitian will explain **program options** (including CWC PCN services, community resources, and self-management resources) to you. Together, you and the Primary Care Registered Dietitian will determine the most **suitable care plan for you**.

All **information** discussed during these calls **is confidential**.

## Cancellation policy

Please contact the CWC PCN at 403.984.6533 as soon as possible to cancel your appointment.

Primary Care Network
CALGARY WEST CENTRAL

# Physiotherapy Program

COMMUNITY SERVICES

The CWC PCN's Physiotherapy Program provides eligible, referred patients a **one-on-one** virtual appointment with a Physiotherapist to expertly assess their needs and determine the most appropriate type of care.

Patients are then connected to the **most appropriate type of care:**

- In-person, one-on-one physiotherapy appointments (up to six appointments)
- In-person GLA:D Hip and Knee Osteoarthritis program (two education sessions and 12 group exercise sessions)
- Exercise-based rehabilitation plan developed by our Physiotherapists with the patient for self-management (our Physiotherapists will then follow up with the patient virtually)
- Referred to an AHS or community-based program (e.g., Alberta Healthy Living Program, etc.) — please follow up with your patients referred outside of our Physiotherapy Program

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| REFERRAL | Referral form |
| CONTACT | Physician Liaison |
| FOR PHYSICIANS AND PROVIDERS | |
| Impact | |
| How to refer | |
| ROLE PROFILE | |
| Physiotherapist | |
| FOR PATIENTS | |
| Information for patients | |
| APPOINTMENT DETAILS | |
| WAIT TIME | Three business days for initial call to set up an appointment. |
| LENGTH | 30 minutes |
| HOURS | Monday to Friday<br>8:30 a.m. - 4:30 p.m. |
| TYPE | Virtual (video call, phone call) |
| CONTRACTED SERVICE PROVIDER DETAILS | |
| Locations and hours | |

**Eligibility**

This service is available for motivated patients who require physical rehabilitation and/or pain management for one of the primary concerns below and are ineligible for coverage by other health payers and unable to pay for services out of pocket:

- Rotator cuff-related shoulder pain that limits activity and participation in the community

- Joint-related degenerative hip and/or knee pain due to osteoarthritis that limits activity participation in the community

For ineligible patients, we have compiled a concise summary of alternative services.

### Impact

Patients will have access to one-on-one physiotherapy assessments. Our Physiotherapists will then assist patients with exercise-based rehabilitation plans and follow-up or referral to the most appropriate type of care based on the specific needs, improving quality of life and leading to a virtuous cycle of improvement of other health conditions.

### How to refer

Please complete the *CWC PCN Physiotherapy Program Referral Form* found in your clinic's EMR to refer patients.

If this referral form is not yet in your EMR, you can download the form and upload it to your EMR files.

Alternatively, or if your clinic does not use an EMR, this form can be printed and faxed to 587.387.7264

### Hours and locations

All contracted service provider locations are displayed on this map to offer an at-a-glance overview.

For one-on-one physiotherapy appointments, Peak Health & Performance is the contracted service provider with four locations:

- 5004 Elbow Dr. S.W.
- 105-3519 14th St. S.W.
- 208-7337 Macleod Tr. S.W.
- 159-2515 90th Ave. S.W.

Hours of operation are 7 a.m. - 8 p.m., Monday - Thursday; 7 a.m. - 7 p.m., Friday; and 9 a.m. - 4 p.m. on Saturday.

For the GLA:D Hip and Knee Osteoarthritis program, Momentum Health is the contracted service provider with seven locations:

- 4-12192 Symons Valley Rd. N.W.
- 1c-7005 18th St. S.E.
- 2200-8561 8A Ave. S.W.

- 5146-901 64th Ave. N.E.
- 312-3320 17th Ave. S.W.
- 129-3815 Front St. S.E.
- 110-7 Mahogany Plz. S.E.

Their hours vary slightly by location but are generally 7 a.m. - 8 p.m., Monday - Friday, and 9 a.m. - 2 p.m. on Saturday.

### Information for patients

Within three business days of referral, the referred patient will receive a call from the Program Coordinator to book the initial appointment with one of our Physiotherapists. During this appointment, our Physiotherapist will:

- Connect virtually and provide assessment services to determine the right treatment for the patient's needs (one of the following):
    - Referral to one-on-one physiotherapy appointments from Peak Health & Performance for shoulder
    - Referral to the GLA:D Hip and Knee Osteoarthritis program from Momentum Health for hip and knee
    - Creation of a self-management program utilizing online tool platform
    - Provision of resources and/or programs to better fit the patient needs
- Provide information to the patient for next steps
- Provide follow up if appropriate

# Physiotherapy Program patient handout

Your doctor has **referred you to** the Calgary West Central Primary Care Network (CWC PCN) **Physiotherapy Program.**

You will **receive a phone call** to book your initial, one-on-one virtual appointment with a CWC PCN Physiotherapist so that you can discuss your needs in greater detail. Together, you will determine the most appropriate type of care for you going forward.

This service is **available at no cost to you.**

| CONTACT | |
|---|---|
| WEBSITE | cwcpcn.com |
| PHONE | 403.984.6533 |
| **APPOINTMENT DETAILS** | |
| COST | Free |
| WAIT TIME | Three business days for initial call to set up an appointment. |
| HOURS | Monday to Friday<br>8:30 a.m. - 4:30 p.m. |
| TYPE | Virtual (video call, phone call) |
| LENGTH | 30 minutes |

## What you should know before your appointment

Your first phone call will come from our Program Coordinator; during this call, you will **schedule time** with one of the CWC PCN's Physiotherapists.

Your scheduled **initial virtual** consultation appointment will last approximately 30 minutes. During this call, you and the Physiotherapist will discuss your needs and goals as it relates to your referral reason. The Physiotherapist will explain **program options** to you (including the options available through the Physiotherapy Program, community resources, and self-management resources). Together, you and the Physiotherapist will determine the most **suitable care plan for you.** If your care plan includes in-person physiotherapy services, information will be provided to you around next steps.

All **information** discussed during these calls **is confidential.**

## Cancellation policy

Please contact the CWC PCN at 403.984.6533 as soon as possible to cancel your appointment.

Primary Care Network
CALGARY WEST CENTRAL

# RhoGAM/WinRho referral service

COMMUNITY SERVICES

This same-day service provides **timely access to RhoGAM/WinRho** for Rh-negative patients at the time of **miscarriage,** during pregnancy, or post-partum. **Encounter notes** are **faxed immediately** to the patient's family physician following the appointment to maintain continuity of care.

RhoGAM/WinRho is recommended for the **prevention of Rh immunization** of Rho(D) negative women at risk of developing Rh antibodies. RhoGAM/WinRho should be administered to women satisfying the above conditions at about 28 weeks gestation when the child's father is Rho(D) positive or unknown.

RhoGAM/WinRho should be administered within 72 hours after delivery if the baby is Rho(D) positive or unknown. RhoGAM/WinRho administration is recommended in women within 72 hours after spontaneous or induced abortion, amniocentesis, chorion villus sampling, ruptured tubal pregnancy, abdominal trauma, or transplacental hemorrhage unless the blood type of the fetus or father are confirmed to be Rho(D) negative. RhoGAM/WinRho should be administered as soon as possible in the case of maternal bleeding due to threatened abortion.

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| REFERRAL | Referral form |
| CONTACT | Physician Liaison |
| **FOR PHYSICIANS AND PROVIDERS** | |
| How to refer | |
| **FOR PATIENTS** | |
| Information for patients | |
| **LOCATION DETAILS** | |
| ADDRESS | Primary Care Centre<br>5960 Centre St. S., Calgary |
| HOURS | Monday to Friday<br>9 a.m. - 9 p.m.<br>Weekends and holidays<br>9 a.m. - 4 p.m. |
| **APPOINTMENT DETAILS** | |
| WAIT TIME | Within 24 hours |
| LENGTH | 15 minutes |
| TYPE | One-on-one |

## Impact

Rho(D) Immune Globulin prevents the development of Rh antibodies in the Rho(D) negative and previously not sensitized mother carrying a Rho(D) positive fetus, thus preventing the occurrence of hemolytic disease in the fetus or the newborn.

## How to refer

To refer your patient, please use the RhoGAM/WinRho referral form and fax the completed document and necessary blood work/antibody screen (completed within nine months of referral) as indicated to 403.258.2748.

## Information for patients

- **Location:** Primary Care Centre, 5960 Centre St. S., Calgary
- **Accessibility:** Free parking, seven-minute walk from Chinook transit station
- **Appointment details:**
    - The patient should arrive 5 - 10 minutes early.
    - The patient must be prepared to remain in clinic for 30 minutes to be monitored for adverse reactions to the injection.
    - If the patient must cancel the appointment, they need to contact the Primary Care Centre at 403.249.9907.

# RhoGAM/WinRho patient handout

Your doctor has **referred you to** the Calgary West Central Primary Care Network (CWC PCN) **Primary Care Centre** for same-day access to RhoGAM/WinRho, a blood product given to Rh-negative patients during pregnancy, post-partum or at the time of miscarriage. This service can only be accessed by referral from your family doctor.

You will **be contacted by phone** by the CWC PCN Primary Care Centre to book your appointment.

This service is **available at no cost to you.**

| CONTACT | |
|---|---|
| WEBSITE | cwcpcn.com |
| PHONE | 403.249.9907 |
| **LOCATION DETAILS** | |
| HOURS | Monday to Friday<br>9 a.m. - 9 p.m.<br>Weekends and holidays<br>9 a.m. - 4 p.m. |
| LOCATION | Primary Care Centre<br>5960 Centre St. S., Calgary |
| ACCESSIBILITY | Free parking, seven-minute walk from Chinook Train Station. |
| **APPOINTMENT DETAILS** | |
| COST | Free |
| WAIT TIME | Within 24 hours |
| TYPE | One-on-one |
| LENGTH | 15 minutes |

## What you should know before your appointment

Please arrive 5 - 10 minutes early and be prepared to remain in clinic for 30 minutes to be monitored for adverse reactions to the injection.

## Cancellation policy

Please contact the Primary Care Centre at 403.249.9907 as soon as possible to cancel your appointment.

Primary Care Network
CALGARY WEST CENTRAL

# Senior Services

COMMUNITY SERVICES

The CWC PCN has a robust Senior Services team, focused on providing integrated, team-based consultative care to patients who are 65 years or older or physiologically aged. The Senior Services team comprises a **specialized team** (e.g., registered nurses and physicians with geriatric expertise, social workers, etc.).

The Senior Services team can **complete in-depth assessments** that may include cognitive screening, functional assessment, environmental risk assessment, medication review, fall assessment, or nutritional assessment. They also play a key role as an **advocate** for patients who may be isolated or without family, ensuring access to care and supports. They are experts in navigating the healthcare system and community support system, often assisting patients and families with accessing appropriate services in a timely manner.

They can see patients in their home, virtually, at the family physician's office, or at the Primary Care Centre.

| MEMBER BENEFIT | |
|---|---|
| A S E C | |
| TARGET POPULATION | Seniors |
| AGE RANGE | 65-plus or physiologically aged |
| REFERRAL | Referral form |
| CONTACT | Physician Liaison |
| FOR PHYSICIANS AND PROVIDERS | |
| Eligibility | |
| Impact | |
| How to refer | |
| FOR PATIENTS | |
| Information for patients | |
| LOCATION DETAILS | |
| HOURS | Monday to Friday<br>8 a.m. - 4 p.m. |
| APPOINTMENT DETAILS | |
| WAIT TIME | Varied |
| LENGTH | Varied |
| LIMIT | Varied, approximately one - three visits |
| TYPE | Home; community; Primary Care Centre; family physician office |

## Eligibility

All CWC PCN physician members' patients who are 65-plus or physiologically aged. Patients who are younger may be accepted, depending on the referral need (e.g., young onset dementia).

## Impact

Improved coordination and continuity of care; increased access to specialists; improved treatment planning and goal setting; improved health outcomes; and improved communication between both patient and provider and across service providers.

## How to refer

CWC Primary Care Centre referral form.

## Information for patients

In-home or in-clinic assessments with clinicians trained in seniors health to discuss concerns and identify patient priorities and resource navigation as appropriate. Appointment may be with a Registered Nurse, Licensed Practical Nurse, Pharmacist, Physician, Social Worker, or a combination of these providers. Patient teaching is provided throughout the visit.

If possible and appropriate, patients should try to have a family member or caregiver present for the assessment. The appointment may be several hours in length, depending on assessments and patient needs.

# Senior Services patient handout

Your doctor has **referred you** to the Calgary West Central Primary Care Network (CWC PCN) **Senior Services** program **for an assessment** with clinicians trained in seniors health to discuss concerns, identify your healthcare priorities, and provide support with resource navigation.

**Your appointment may be with a** Registered Nurse, Licensed Practical Nurse, Pharmacist, Physician, Social Worker, or a combination of these providers.

You will **receive a phone call** from the CWC PCN to book your appointment. You may be seen in your home, virtually, at your family doctor's office, or at the Primary Care Centre.

This service is **available at no cost to you.**

| CONTACT | |
|---|---|
| WEBSITE | cwcpcn.com |
| PHONE | 403.686.0020 |
| **LOCATION DETAILS** | |
| HOURS | Monday to Friday<br>8 a.m. - 4 p.m. |
| LOCATION | Primary Care Centre<br>5960 Centre St. S., Calgary<br>*Virtual, home, and community visits available. |
| ACCESSIBILITY | Free parking, seven-minute walk from Chinook Train Station. |
| **APPOINTMENT DETAILS** | |
| COST | Free |
| WAIT TIME | Varied |
| TYPE | One-on-one, family |
| LENGTH | Varied |

## What you should know before your appointment

If possible and appropriate, you should try to have a family member or caregiver present for the appointment.

The appointment may be several hours in length, depending on assessments and patient needs.

## Cancellation policy

Please contact Seniors Services at 403.686.0020 as soon as possible to cancel your appointment.

Primary Care Network
CALGARY WEST CENTRAL

# 24-hour blood pressure monitoring

COMMUNITY SERVICES (EXTERNAL)

All members can refer their patients for 24-hour blood pressure monitoring to their choice of **four providers with six locations** using the CWC PCN's single, combined referral form. A device will measure the patient's blood pressure (BP) at regular intervals, providing a clear picture of how BP changes as patients move through their typical day.

The selected service provider will book referred patients a setup appointment and a corresponding removal appointment 24 hours later, at which time the results and the interpretation of results are faxed to the referring physician.

This service is offered at **no cost to patients.**

The four no-cost options in Calgary to which members can refer for 24-hour BP monitoring using the form are Advanced Cardiology, Advanced Respiratory Care Network, C-diagnostics (a division of C-health), and Core Pharmacy.

MEMBER BENEFIT

P A S E C

| REFERRAL | Referral form |
|---|---|

FOR PHYSICIANS AND PROVIDERS

How to refer

LOCATION DETAILS

**Advanced Cardiology**
250 8500 Blackfoot Tr. S.E. | 403.879.7911
201-3151 27th St. N.E. | 403.235.4109

**Advanced Respiratory Care Network**
250-8730 Country Hills Blvd. N.W. | 403.873.0891
225-40 Sunpark Plz. S.E. | 403.873.0891

**C-diagnostics (a division of C-health)**
210-1016 68th Ave. S.W. | 403.541.003

**Core Pharmacy**
201-722 85th St. S.W. | 403.454.2333

## Eligibility

Twenty-four-hour blood pressure monitoring is available by booked appointment only, based on a referral from a CWC PCN physician member.

## Impact

To rule out the white coat effect, to monitor the effects of medications on blood pressure, or to investigate whether blood pressure stays high; eliminates the need for clinics to maintain their own 24-hour blood pressure equipment.

## How to refer

To refer, please complete the referral form in your EMR — search for “CWC PCN 24h BP Referral Form” — (or download the PDF referral form) and fax it to the location of your choice:

- **Advanced Cardiology with two locations:**
  - 250 8500 Blackfoot Tr. S.E.; fax to 403.879.7899
  - 201-3151 27th St. N.E.; fax to 403.235.4147
- **Advanced Respiratory Care Network with two locations:**
  - 250-8730 Country Hills Blvd. N.W.; fax to 403.735.5163
  - 225-40 Sunpark Plz. S.E.; fax to 403.873.1817
- **C-diagnostics (a division of C-health) with one location:**
  - 210-1016 68th Ave. S.W.; fax to 403.541.0032
- **Core Pharmacy with one location:**
  - 201-722 85th St. S.W.; fax to 403.454.9466

# Prescription to Get Active

COMMUNITY SERVICES (EXTERNAL)

Prescription to Get Active (RxTGA) is a uniquely designed prescription that gives patients of all ages **free access** to activity resources, recreation centres, and advice on increasing their physical activity. Physician members can participate as prescribers, providing their eligible patients free access to:

- Trials at over 145 recreation and fitness facilities in Alberta
- Trials for online movement and exercise videos led by qualified fitness instructors
- Remote engagement and behavioural support
- Downloadable guides

The **goal** of the program is to support individuals to become more active, to equip physicians and their healthcare teams with tools to educate patients on the importance of physical activity, and to partner with recreation facilities to provide accessible spaces within all communities.

MEMBER BENEFIT

P A S E C

| | |
|---|---|
| WEBSITE | prescriptiontogetactive.com |
| FAQ | prescriptiontogetactive.com |
| CONTACT | Physician Liaison |

FOR PHYSICIANS AND PROVIDERS

Registration and access

## Eligibility

All CWC PCN physician members are eligible to be prescribers of the RxTGA program.

## Impact

Patients are supported to become more active. Family physicians and their healthcare teams are enabled to educate their patients on the importance of physical activity.

### Registration and access

**Step 1:** Family physicians and their healthcare teams identify patients who are:

a. Below the Canadian Physical Activity and Sedentary Behaviour Guidelines:
   - Less than 60 minutes per day for children and youth (0 - 17 years old).
   - Less than 150 minutes per week for adults and seniors (18 - 65-plus years old).

b. Able to participate in unsupervised physical activity without medical clearance.

**Step 2:** Prescribers provide a specially designed prescription to their patients. There are **three prescription options** available:

- **Paper prescription (for in-person appointments):** Members can request paper prescription pads from their Physician Liaison or Member Services & Engagement.
- **EMR prescription (for in-person appointments):** The Prescription to Get Active form can be found on Accuro, AVA, CHR, Health Quest, Med Access, and PS Suite EMRs by searching "Prescription to Get Active."
- **Verbal prescription (for virtual appointments):** During a virtual appointment, healthcare professionals can provide patients with a verbal prescription and direct them to register for the program on the RxTGA website.

**Step 3:** Patients record their prescription at prescriptiontogetactive.com.

**Step 4:** Registered patients have free access to evidence-based programming and resources online or remotely to support safe and convenient physical activity, including:

- No obligation trials for online movement and exercise videos led by qualified fitness instructors.
- Remote engagement and behavioural support.
- Downloadable guides (e.g., Balance Guide for Seniors, Stretching Program).

Patients can also take their prescriptions to participating recreation facilities and receive free trial access.

**Please note:** Patients can receive more than one prescription; however, individual recreation facilities will not accept a second prescription for the same person.

# Specialist Link

COMMUNITY SERVICES (EXTERNAL)

Specialist Link is an innovative service that **connects family doctors, nurse practitioners,** and **specialists** in the Calgary area. Developed through a unique partnership between the seven Calgary and area Primary Care Networks and Alberta Health Services, its goal is to improve patient care.

Specialist Link includes a **real-time, physician-only tele-advice line, clinical care pathways,** and **other resources** that support family physicians to care for their patients and help improve communication and collaboration between primary and specialty care.

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| WEBSITE | Specialist Link |
| FAQ | Specialist Link |
| CONTACT | 403.910.2551 Ext. 0<br>Specialist Link |

## Eligibility

Specialist Link is a physician-only service. All CWC PCN physician members are eligible to access the tele-advice line, clinical care pathways and resources.

## Impact

Collaboration between primary and specialty care and improved patient care.

## Access

### Tele-advice

Request tele-advice online by visiting the Specialist Link website and hovering your mouse over the specialty list in the tele-advice section. Click to submit a request. You can also call 403.910.2551 or 1.844.962.5465.

Services are available Monday to Friday (except holidays), 8 a.m. to 5 p.m. (chronic pain, child and adolescent and geriatric psychiatry, maternal fetal medicine, refugee health and respirology until 4 p.m.). Calls are returned within one hour.

### Clinical Pathways

Visit the Specialist Link website and click on the appropriate specialty in the clinical pathways section to reveal related pathways. Note: Pathways are based on evidence-based best practice but do not override the responsibility of providers to make decisions based on their clinical judgment.

### Resources

Access resources by visiting the physician resources or mental health pages on the website.

# Member Services & Engagement

*Providing responsive, two-way communication and programs to keep members involved and informed.*

# MSE overview

Recognizing that physician members are the CWC PCN's foundation, the Member Services & Engagement (MSE) teams provide responsive, two-way communication and programs to keep members involved and informed.

MSE helps members stay up to date with multiple communications channels and contacts that provide timely information and ways for members to engage with their PCN. MSE also has practice support programs and coordinates CME & PD opportunities that are tailored for members.

MSE programs and services are offered through the Practice Support Program, the Physician Engagement Program, and the Continuing Medical Education & Professional Development program.

### Continuing Medical Education & Professional Development Program

- CME & PD

### Physician Engagement Program

- Member engagement
- Member-facing communications

### Practice Support Program

- Lexidrug
- Member discounts
- Occupational Health and Safety support
- PCN-branded materials
- Privacy training and resources
- Transition support services
- Translation Services
- Unattached patient registry
- UpToDate

# CME & PD

CONTINUING MEDICAL EDUCATION & PROFESSIONAL DEVELOPMENT

Organized by the CWC PCN and in conjunction with the Calgary Zone, community partners, and our members, the continuing medical education & professional development (CME & PD) program supports physicians with **free educational opportunities.** Both **Mainpro+ certified** and **non-certified event** opportunities are available.

We've designed the program to meet the following objectives:

- Help members run effective and compliant practices
- Build connections and relationships within the membership and with local community partners
- Develop a community of practice for members to share Patient's Medical Home expertise and learnings
- Provide members information on provincial and zonal primary care initiatives

CME & PD content is identified through various ongoing engagement activities with our membership to ensure that topics are timely, relevant, and tailored to family physician practices. Priority areas for education include:

- Practice support
- Community Services, Transitions, and Integration
- Patient's Medical Home
- Primary care partnerships

Please contact your Physician Liaison if you have a CME & PD topic suggestion in one of the priority areas.

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| CONTACT | Physician Liaison |
| FOR PHYSICIANS AND PROVIDERS | |
| Eligibility | |
| Impact | |
| Registration and access | |

## Eligibility

Standard, Enhanced, and Comprehensive members and pediatricians are eligible for all CME & PD opportunities. Associate members' eligibility varies based on CME & PD offering type; please contact your Physician Liaison for details. CME & PD invitations are extended to clinic staff of CWC PCN members as well as CWC PCN clinical staff when appropriate.

## Impact

Enhance education and skills to improve members' practices and patient care. With each program, attendees have the opportunity to complete a satisfaction survey. Information provided helps inform future events.

## Registration and access

CME & PD opportunities are promoted to members by direct email campaigns, Physician Liaison outreach, and the CWC PCN's e-newsletter. Interested members can register through a registration link in the communications. Many offerings have an unlimited capacity. For events with limited spots, a waitlist is maintained to fill potential cancellations.

The CWC PCN has a no-show policy for programs with limited availability and where significant costs were incurred for the programming. Please refer to the event invitation and confirmation messaging for these event-specific details.

We recognize extenuating circumstances result in schedule changes, and members can appeal no-show occurrences. As such, our policy includes reminders and warnings before the consequence of losing eligibility.

# Member engagement

PHYSICIAN ENGAGEMENT PROGRAM

The CWC PCN **engages with its physician members** to ensure they are up to date on services and to **collect feedback** to improve programs, tools, and resources.

Members have access to an assigned Physician Liaison and opportunities to participate in focus groups, interviews, surveys, and to serve on the Board.

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| WEBSITES | Physician Liaisons Board |
| CONTACT | Physician Liaison |
| FOR PHYSICIANS AND PROVIDERS | |
| Impact | |
| ROLE PROFILE | |
| Physician Liaison | |

## Program details

### Physician Liaisons

Physician Liaisons promote, facilitate, and enhance CWC PCN programs and services through regular contact with physicians and clinic staff. They work proactively to build strong relationships, promote two-way communication, and generate awareness regarding PCN programs and services.

Physician Liaisons are members' primary contact for questions about the CWC PCN. They will meet with members and clinic staff regularly to share information, answer questions, and solicit suggestions to help with program planning and improvement.

Each member is assigned a Physician Liaison with the CWC PCN.

### Focus groups and interviews

The CWC PCN conducts focus groups and interviews to engage with members on a variety of relevant topics. These opportunities are offered as they become available, and participating members are remunerated for their time.

### Surveys

The CWC PCN gathers information via surveys to better understand members and their practices and guide program and service planning. There are periodic surveys on topics of interest and an annual Membership Check-in Survey to assess physicians' progress in building their PMH and health team effectiveness.

### Board

The CWC P.G. Co. Board of Directors are elected representatives of the membership who provide oversight and direction to the organization. Board members are passionate about primary health care and committed to the Patient's Medical Home and the delivery of PCN programs and services in the community. Members are eligible to run for election at the CWC PCN annual general meeting and can apply to serve on a subcommittee.

### Impact

Physician members engage in shaping current and future programs and services to ensure we are meeting the needs of their patients and their practices.

# Member-facing communications

PHYSICIAN ENGAGEMENT PROGRAM

The CWC PCN **uses multiple communications channels** to send members information while **respecting their preferences** and complying with Canada's Anti-Spam Legislation.

The PCN's e-newsletters and text messages are sent to members based on different subscriptions so members can choose to not receive some content without unsubscribing from all communications.

Members can also visit the PCN's physician-specific website at any time.

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| WEBSITES | Member-facing website |
| CONTACT | Physician Liaison |
| FOR PHYSICIANS AND PROVIDERS | |
| Impact | |

## Program details

### E-newsletter platform

There are four subscriptions used to email members important program updates, CME &PD invitations, and reoccurring e-newsletters based on their preferences:

- Examiner: The main member subscription for the biweekly Examiner e-newsletter and important emails about the PCN.
- Calgary Zone: Initially created to distribute the Pandemic Response e-newsletter, this subscription is now used to distribute the Calgary Zone news and updates e-newsletter.
- CME & PD: The subscription used to send members CME & PD invitations.
- Wellness Watch: The subscription for the monthly physician-wellness focused e-newsletter.

### Text messaging platform

All text messages from the CWC PCN come from a verified toll-free number — 1.844.501.1418 — so members know the links are safe to click. There are three subscriptions in the text messaging platform so members can choose to not receive text messages they do not want:

- High priority: The original text message subscription for urgent or important announcements and priority messages related to the Board and our Executive Director.

- CME & PD promotion: Text messages to launch the promotion of new CME & PD opportunities so members can quickly find the invite and register.
- Programs and services updates: Text messages about changes to programs and services or the launch of a new program so that members are up to date and able to get the most out of PCN services.

### Website

The PCN's member-facing website, cwcpcndocs.com, provides members a single place for PCN news, CME & PD invites and recording, programs and services details, forms, and more.

### Impact

Physician members can select what information they receive so they are informed and up to date on PCN programs and services, CME & PD offerings, information relevant to primary care, and the Calgary Zone per their preference.

# Lexidrug

PRACTICE SUPPORT PROGRAM

Lexidrug (formerly Lexicomp) is an online clinical support tool with **point-of-care drug information** and clinical content, such as clinical practice guidelines, IV compatibility, drug comparisons, and other tools. A wide array of databases enables our members to quickly locate information on an extensive range of topics, including pediatric, adult, and geriatric dosing and guidelines, patient education, international drugs, infectious diseases, and pregnancy and lactation.

The CWC PCN provides members with **complimentary subscription.**

**Note:** Although a more basic version of Lexidrug is available through the CWC PCN's complimentary UpToDate subscription, the full version of Lexidrug provides more comprehensive drug information and patient information leaflets in multiple languages.

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| WEBSITE | wolterskluwercdi.com |
| CONTACT | Physician Liaison |

## Registration and access

Access to a Lexidrug subscription is provided to members through their clinic's public IP address. To start the process to access Lexidrug, please email your Physician Liaison or Member Services & Engagement.

Members will then receive an email with details on the step to get a subscription and how to access Lexidrug when in the clinic. Access to the Lexidrug subscription from any location is available via a mobile application. Following the initialization of the subscription, Lexidrug can generate an access code that permits the use of Lexidrug through mobile platforms away from the clinic IP address. The access code needs to be reapplied only once per year, and you will see prompts on your mobile device.

Lexidrug demos can be provided either by a Physician Liaison or through Lexidrug. Please email Member Services & Engagement for a demonstration.

# Member discounts

PRACTICE SUPPORT PROGRAM

| | MEMBER BENEFIT | |
|---|---|---|
| The CWC PCN brings members **exclusive offers** and **discounted rates** from multiple businesses and shares discounts for healthcare workers from other organizations. | P A S E C | |
| | WEBSITE | cwcpcndocs.com/discounts |
| | CONTACT | Physician Liaison |

## Discount details, registration, and access

Please visit the member discounts web page on cwcpcndocs.com for details on all current discounts for members and instructions on how to access them.

If you know of other discounts for physicians to add to the web page, please email Member Services & Engagement.

## Impact

CWC PCN physician members are provided with discounts on programs and services that support their well-being and practice.

# Occupational Health and Safety support

PRACTICE SUPPORT PROGRAM

There is a shared responsibility between the CWC PCN and member clinics to ensure a suitable work environment for PCN staff. To **minimize** the occurrence of **workplace incidents, injuries, and illnesses,** we have instituted an occupational health and safety management system and offer resources to assist our members and their clinics.

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| WEBSITE | cwcpcndocs.com/resources for your clinic |
| CONTACT | Physician Liaison |
| FOR PHYSICIANS AND PROVIDERS | |
| Impact | |

## Program details

The CWC PCN is committed to providing a healthy and safe work environment. We are pleased to offer several resources to assist our members and their clinics in meeting Occupational Health and Safety (OHS) legislation, including but not limited to:

- OHS assessments
- Links to OHS legislation
- The CWC PCN Blood and Body Fluid Exposure (BBFE) Protocol
- De-escalating Potentially Violent Situations (video training)

A complete list of our resources can be found on cwcpcndocs.com.

### OHS assessments

Physician Liaisons or a contracted OHS expert conduct OHS assessments in clinics when CWC PCN staff are first assigned and every two years following. The assessment takes approximately 30 minutes. A binder and checklist are used, and the clinic manger or appointed clinic staff member will complete any outstanding items from the assessment. The clinic is expected to maintain the binder and keep it in the clinic for reference. A complimentary first aid kit is also provided.

Clinics without CWC PCN staff are offered optional OHS assessments as a member benefit.

### CWC PCN BBFE Protocol

The BBFE Protocol clearly outlines the steps to follow if a CWC PCN employee is exposed to blood and/or body fluids. The goal is to reduce the exposed healthcare worker's risk of medical consequences related to the exposure (such as hepatitis and HIV).

The related documents are reviewed during the OHS assessment to ensure the processes are understood and that the clinic is committed to following the processes in the event of a BBFE involving a PCN employee. Clinics can also opt to adopt these processes for all staff and physicians.

This includes the following:

- BBFE Protocol and Process Map
- Protocol Checklist
- Manager BBFE Protocol Checklist
- Employee BBFE Protocol Checklist
- Confirmation of Assessment
- Consent to Disclose
- Release and Waiver of Liability
- Withdrawal of Consent

### Impact

Increased access and support for clinics to meet OHS legislation requirements and provide safe work environments for PCN employees.

# PCN-branded materials

PRACTICE SUPPORT PROGRAM

Branded materials are **available to support physician members** in their clinics and to **build awareness of their membership** with the CWC PCN among patients.

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| ORDER FORMS | cwcpcndocs.com/forms |
| POSTERS | cwcpcndocs.com/resources for your clinic |
| CONTACT | Physician Liaison |
| FOR PHYSICIANS AND PROVIDERS | |
| Impact | |

## Available materials

The CWC PCN is pleased to offer the following PCN-branded materials for your clinic:

### Business cards

These cards double as business and appointment cards with your information and space to write the patient's next appointment on the back.

Card orders are placed in monthly batches on the 15th and are delivered to clinics approximately four weeks later.

Physicians may order in boxes of either 100 or 500. Physicians working in more than one clinic can request up to two versions (maximum 500 cards per clinic per request).

To place an order, complete and submit the Physician Business Card Order Form.

### CWC PCN membership plaque

Physician members may order an optional member plaque to display in their clinic, limited to one per each of their clinics. If you or your clinic are eligible for a plaque, your Physician Liaison will reach out during the annual ordering period.

### In-clinic posters

Members and clinic staff can review and print the available posters by visiting the dedicated web page on cwcpcndocs.com. When new posters are introduced, clinics have the opportunity to place an order for printed posters at no cost to the clinics.

### Impact

CWC PCN physician members are provided with branded materials that assist their clinic and build awareness of their membership among patients.

# Privacy training and resources

PRACTICE SUPPORT PROGRAM

To assist members in adhering to privacy legislation, the CWC PCN offers access and links to an online **privacy training module,** Privacy Impact Assessment (PIA) templates and support, and information about breach reporting.

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| WEBSITE | cwcpcndocs.com/resources for your clinic |
| CONTACT | Physician Liaison |
| FOR PHYSICIANS AND PROVIDERS | |
| Impact | |

## Eligibility

These privacy resources, tools, and training are available to all members and their clinic staff.

## Resource details

### Online privacy training

This customized training module contains an overview of the *Health Information Act* (HIA) of Alberta's requirements, technical challenges that can compromise health information compliance, and suggestions for implementing safeguards and best practices.

Access the module.

The AMA also offers interactive privacy training through the online Learn@AMA platform. The on-demand training allows physicians and clinic staff to learn at their own pace, discuss topics of interest with their peers, and access helpful resources and tools. Visit the AMA's privacy training web page to learn more.

### PIA: Clinic guidelines

Under Alberta's HIA, custodians must submit PIAs to the Information and Privacy Commissioner before implementing practices or information systems that will collect, use, or disclose individually identifying health information. This includes changes to existing practices or information systems.

The CWC PCN's privacy team is able to assist members and/or their representatives in determining the specific requirements necessary to maintain a level of compliance acceptable under the HIA.

Access the resources and template.

### Privacy Breach Management

It is mandatory for a custodian having individually identifying health information in its custody or control to notify the commissioner, as soon as practicable, of a privacy breach if the custodian determines there is a risk of harm to an individual as a result of the loss or unauthorized access or disclosure (section 60.1(2)). Information is available to our members acting as health information custodians.

Access the resource.

### Impact

Our goal is to provide members with the resources and/or tools to demonstrate their commitment to the protection of patients' health information while in their custody and/or control.

# Transition support services

PRACTICE SUPPORT PROGRAM

The CWC PCN offers physician members support during a transition into or out of a clinic **independent from** and in **addition to** the physician's responsibilities outlined by the College of Physicians & Surgeons of Alberta's Standards of Practice. This includes support with:

- Selling your practice to another physician
- Closing your practice and transitioning patients
- Joining a practice within the CWC PCN

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| CONTACT | Physician Liaison |

## Eligibility

Any current or prospective members of the CWC PCN.

## Details

Depending on the nature of the transition, the CWC PCN is able to support advertising/promotion activities as well as patient outreach to help ensure continuity of care for patients and to support members.

## Access

Talk with your Physician Liaison or email Member Services & Engagement.

# Translation Services

PRACTICE SUPPORT PROGRAM

Translation Services gives members and their clinic staff access to **over-the-phone translation** support for themselves and their patients.

Members can access the service for free using the CWC PCN's **client ID** and a unique **secondary code** for each clinic in which they work.

Translation Services are provided by LanguageLine Solutions' highly trained professional linguists **24 hours a day, seven days a week** in over 240 languages.

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| WEBSITE | cwcpcndocs.com |
| TIPS | cwcpcndocs.com |
| CONTACT | Physician Liaison |

## Impact

Physician members are provided with a translation tool to assist with patient communication, support them in their practice, and provide comprehensive care.

## Registration and access

To access an interpreter, members require the CWC PCN client ID (277749) and a unique secondary code for each clinic in which they work.

To obtain the secondary code(s), members must contact their Physician Liaison. Access must be requested by physician members only. Please consult the full instructions for using the service.

# Unattached patient registry

PRACTICE SUPPORT PROGRAM

The Alberta Find a Doctor website (also known as the Unattached Patient Registry) is designed to make it **easier and quicker for patients in Alberta to find a family doctor.** Research shows patients who have a family doctor and visit them regularly are healthier as they age and live longer.

Patients can request a physician contact them by clicking “Help me find a doctor” and completing the website registration or search the listed physicians via “Find a doctor” and contact the clinic. Physicians accepting new patients can reach out to unattached patients who have registered on the website.

| MEMBER BENEFIT | |
|---|---|
| A S E C | |
| REGISTRATION | Registration form |
| WEBSITE | albertafindadoctor.ca |
| CONTACT | Physician Liaison |

## Eligibility

CWC PCN members practicing family medicine.

## Impact

The Alberta Find a Doctor website improves access for patients and continuity of care by helping patients find a personal family physician. Patients receive more chronic disease care, make fewer visits to the emergency department, and are hospitalized less. For physicians, the website can help build their panel.

## Registration and access

Participating physicians are added to the website upon becoming a member of the CWC PCN. Physicians, or a delegated administrator from their clinic, must complete the Unattached Web Registry - User Training form to have an account created by the PCN’s Member Services Coordinator. This account will allow them to claim patients on the website. Clinics can claim patients without being listed as ”accepting” on the website.

# UpToDate

PRACTICE SUPPORT PROGRAM

UpToDate is an **evidence-based clinical decision support resource** that can assist healthcare practitioners in making decisions at the point of care.

The CWC PCN provides members with a **complimentary subscription.**

The knowledge in UpToDate is evidence-based and continuously updated. It is presented as a comprehensive synthesis of the evidence followed by recommendations that can be acted on at the point of care. UpToDate combines an advanced publishing platform with the rigour of a sophisticated editorial process managed by a faculty of accomplished physician authors and editors who are renowned leaders in their specialties.

UpToDate also offers subscribers mobile access options, tools and graphics, complementary patient information articles, and more. It is accredited as a continuing education resource by many organizations including colleges, associations, and authorities from around the world.

Activity on UpToDate can qualify for Mainpro+ credits.

| MEMBER BENEFIT | |
|---|---|
| P A S E C | |
| REGISTRATION | Contact your Physician Liaison |
| WEBSITE | uptodate.com/home |
| FAQ | uptodate.com/home/help |
| CONTACT | Physician Liaison |
| FOR PHYSICIANS AND PROVIDERS | |
| Impact | |
| Registration and access | |

## Impact

UpToDate supports members in making evidence-based decisions and providing patients with educational resources for self-management, thus improving patient care.

### Registration and access

To register, members must email their Physician Liaison with a request for an UpToDate subscription and the email address they want the subscription to use. They will then receive a confirmation email from the Member Services Coordinator, as well as UpToDate, with information on how to activate their subscription. Subscriptions not activated within 30 days may be cancelled. Please note: We are not able to merge accounts from other PCNs.

# Appendix

# Acronym Glossary

PROGRAMS & SERVICES GUIDE

| ACRONYM | DEFINITION |
|---|---|
| ACT | Acceptance and Commitment Therapy |
| AMA | Alberta Medical Association |
| ASaP | Alberta Screening and Prevention program |
| BG | Blood Glucose |
| BBFE | Blood and Body Fluid Exposure |
| BP | Blood Pressure |
| CAP | College of Alberta Psychologists |
| CBT | Cognitive Behavioural Therapy |
| CHIMA | Canadian Health Information Management Association |
| CII/CPAR | Community Information Integration/Central Patient Attachment Registry |
| CME & PD | Continuing Medical Education & Professional Development |
| COPD | Chronic Obstructive Pulmonary Disorder |
| CORE-10 | Clinical Outcomes in Routine Evaluation |
| CPG | Clinical Practice Guidelines |
| CSTI | Community Services, Transitions, and Integration |
| CWC P.G. Co. | Calgary West Central Physician Group Corporation |
| CWC PCN | Calgary West Central Primary Care Network |
| DBT | Dialectical Behaviour Therapy |
| ED | Emergency Department |
| EMR | Electronic Medical Record(s) |
| GAD7 | General Anxiety Disorder |
| GDS | Geriatric Depression Scale |
| GERD | Gastroesophageal Reflux Disease |

| ACRONYM | DEFINITION |
|---|---|
| HIA | *Health Information Act* |
| HIC | Health Information Coordinator |
| IBS | Irritable Bowel Syndrome |
| MAC | Member Advisory Council |
| MI | Motivational Interviewing |
| MMSE | Mini-Mental State Examination |
| MSE | Member Services & Engagement |
| OHS | Occupational Health and Safety |
| PCC | Patient Care Coordinator |
| PCRN | Primary Care Registered Nurse |
| PRCP | Primary Care Registered Psychologist |
| PHQ9 | Patient Health Questionnaire |
| PIA | Privacy Impact Assessment |
| PMH | Patient's Medical Home |
| PSP | Panel Support Program |
| R. Psych. | Registered Psychologist |
| RN | Registered Nurse |
| RUDAS | Rowland Universal Dementia Assessment Scale |
| RxTGA | Prescription to Get Active |
| SFT | Solution-Focused Therapy |
| SLUMS | Saint Louis University Mental Status Exam |
| USB | Universal Serial Bus |

# Physician Liaison role profile

Physician Liaisons understand the needs of the primary care physicians and other professionals within the CWC PCN. Through regular contact with physicians and clinics, Physician Liaisons promote, facilitate, and enhance CWC PCN programs and services with physician feedback. They proactively build strong relationships, solicit input, and promote two-way communication.

| Skills | Responsibility | Activities |
|---|---|---|
| • Exhibit strong relationship-management skills to strengthen internal and external relationships | • Support the development of collaborative internal relationships<br>• Build and nurture external relationships with physician members and associated clinic staff | • Ensure physician members and clinic staff are connected to appropriate PCN programs, services, and resources<br>• Identify physician member and clinic staff concerns by investigating and then developing and implementing solutions |
| • Effectively communicate, facilitate, and advocate | • Ensure physician members are provided with the opportunity to engage with the PCN<br>• Support the implementation of PMH model initiatives | • Meet with prospective and new physician members to provide an overview of CWC PCN programs and services<br>• Provide insight and guidance to physician members in their engagement with the PCN<br>• Provide information to members regarding PMH and how the PCN supports physicians in building PMHs |
| • Demonstrate a wide-ranging capacity to solicit, evaluate, and act on feedback and data from physician members and their clinical teams | • Promote informational continuity between the CWC PCN, physician members, and patients | • Interact regularly with physician members and clinic staff to provide information, solicit feedback, and support two-way communication<br>• Process and evaluate feedback to help improve or implement PCN programs and services |

# Primary Care Registered Nurse role profile

The Primary Care Registered Nurse (PCRN) is a member of the healthcare team within the CWC PCN. PCRNs collaborate with physicians and other care providers to assist patients in meeting their health needs.

| | Skills and responsibilities | Activities |
|---|---|---|
| **Patient care** | *Chronic disease focus*<br>• Asthma, COPD, chronic pain, congestive heart failure, chronic kidney disease, diabetes, dyslipidemia, gastrointestinal issues (IBS, GERD, dyspepsia), hypertension, and weight management (except eating disorders)<br>*Tobacco cessation*<br>• Inclusive of cigarettes, cannabis, vaping, etc.<br>*Mental health screening and interventions*<br>• Provides support for mild to moderate mental health concerns by offering behavioural interventions, education, resources, and referrals when appropriate<br>*Basic cognitive screening*<br>• Completes basic cognitive screens: MOCA, SLUMS, RUDAS, and Functional Activities Questionnaire<br>*Women's health*<br>• PCRN provides support throughout the perinatal period<br>*Advanced care planning*<br>• May initiate and support the Most Responsible Care Provider (MRP) with Advance Care Planning and/or Goals of Care Designation conversation (including Green Sleeve education) | • Provides assessment, screening, healthy lifestyle support, and education<br>• Provides patient-centred care and ongoing monitoring based on the patient's individual goals in collaboration with the patient; re-evaluates and adjusts as needed<br>• Provides referrals to approved community and online programs and self-referral information as appropriate<br>• Uses HealthChange Methodology to provide person-centred care, shared decision-making, behaviour change, and self-management<br>• Collaborates with the PMH team and physician to provide comprehensive screening for health issues (e.g., ASaP maneuvers, CPG recommendations)<br>• Provides prenatal education, including nutrition, exercise, prenatal testing, immunizations, prenatal classes, breastfeeding, seatbelt safety, and healthy weight gain |

# Primary Care Registered Psychologist role profile

The Primary Care Registered Psychologist (PCRP) is a regulated member of the interprofessional healthcare team utilizing collaboration and innovation in the provision of primary care services. This team will help build and sustain a community of PMHs within the CWC PCN by providing patients with access to high quality, comprehensive care.

The PCRP is a Registered Psychologist (R. Psych.) in good standing with the College of Alberta Psychologists and uses clinical and social interventions to increase overall mental well-being. Psychologists "assess . . . treat, guide and support persons or groups of persons in order to enhance development, effective living and quality of life or to prevent, remedy or ameliorate mental, emotional, cognitive, behavioural and interpersonal difficulties" (Health Profession Act, Schedule 22, Section 3).

The PCRP abides by regulations set forth by the College of Alberta Psychologists regarding consent, confidentiality, and record-keeping as governed by the Health Professions Act, College Bylaws, Canadian Code of Ethics for Psychologists, and Standards of Practice.

| | Skills and responsibilities | Activities |
|---|---|---|
| **Patient care** | • Able to provide comprehensive counselling/ psychotherapy/telepsychology to individuals across the lifespan<br>• Clinical expertise/scope of practice may include: anxiety, anger, bereavement and grief, burnout, chronic pain, depression, domestic violence, LGBTQIA2S+ and identity topics, occupational problems, pain management, relationship difficulties, self-esteem, self-management of chronic diseases and other health conditions, sleep disturbances, stress, stress-somatization responses, substance abuse, and the needs of the elderly and their caregivers<br>• Knowledge and use of evidence-based interventions, which may include: Acceptance and Commitment Therapy (ACT), Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), Solution-Focused Therapy (SFT), mindfulness-based practices, and more<br>• Able to employ HealthChange Methodology and Motivational Interviewing (MI) to explore patient readiness and stage of change | • Conduct initial assessment or consultation to measure client's needs, goals, and stages of change<br>• Foster a professional and collaborative working relationship with the client<br>• Conduct approximately 30- to 50-minute sessions with individuals and continue subsequent sessions to help meet client needs<br>• Develop collaborative working relationships and engage in ongoing consultations with physicians and the regulated health professionals in the PMH to develop treatment plans, provide interdisciplinary support, and enhance the team's ability to care for patients<br>• Provide psychoeducation and psychotherapy treatment to address a variety of concerns<br>• Employ evidence-based interventions in a manner that emphasizes patient decision-making, skills-training, symptom relief, collaboration, empathy, readiness for change, and self-management |

| | Skills and responsibilities | Activities |
|---|---|---|
| **Patient care** | • Able to complete intakes, screening, and assessment of patient history and use working clinical knowledge to create individualized, thorough treatment plans<br>• Able to help patients monitor the use of psychopharmacology (e.g., first-generation antipsychotics, second-generation antipsychotics, antidepressants, sedatives, hypnotics, anxiolytics, mood stabilizers), if applicable<br>• Able to work with diverse presenting concerns with trauma-informed and multicultural training | • Support patients in enhancing positive health outcomes and improving well-being<br>• Provide referrals to community-based mental health resources and interprofessional practitioners (e.g., Social Workers, Registered Nurses) as needed<br>• Engage in a continuum of care model that includes prevention, treatment, maintenance, and termination<br>• Write clinical progress reports and maintain client records |
| **Person-centred care** | • Utilizes HealthChange Methodology to provide person-centred care and promote health literacy, shared decision-making, behaviour change, and self-management to support adherence to evidence-based recommendations for improved health and quality of life outcomes | • Apply HealthChange Methodology to support patients in self-managing their health conditions |

| | Skills and responsibilities | Activities |
|---|---|---|
| **Quality improvement** | • Develops an understanding of the principles of quality improvement<br>• Applies quality improvement principles in the provision of care<br>• Able to participate in and initiate the implementation of improvement processes within primary care that support improving patient care<br>• Collaborates effectively with the PMH team to achieve change and improvements in patient care<br>• Support and mentor PMH team members and colleagues in the principles of quality improvement<br>• Able to use data to inform decisions about improving patient care both at the patient population and individual care level | • Collaborates with the PMH team to identify patient groups and improvement goals to improve patient care<br>• Works with the PMH team to create care plans for chronic disease patients<br>• Works with the PMH team to coordinate comprehensive screening for mental health issues<br>• Monitor changes over time as a result of improvement goals<br>• Documents improvement goals and expected outcomes and collects relevant information to inform change<br>• Is an active participant in measuring patient outcomes |

# Health Information Coordinator role profile

The Health Information Coordinator (HIC) is an integral and active member of the CWC PCN's PMH team, supporting physician members remotely using EMR systems and digital health platforms. The HIC will primarily support physicians and PMH team members in EMR/data management and the implementation of PMH projects aimed at improving overall patient outcomes. The specific nature of their work is determined by the PMH goals being supported. The HIC will work in tandem with a Patient Care Coordinator to support member clinics and provide coverage for each other when needed.

HICs have successfully completed their Health Information Management Diploma and are certified with the Canadian Health Information Management Association. They are formally trained on managing personal health information and interpreting data to inform decision-making to assist with patient care. Using computer skills and knowledge of healthcare fundamentals, the HIC will coordinate health information using clinical practice guidelines and assist the PMH team to provide robust, quality information to physician members to support the medical home.

The HIC will effectively communicate and work with all members of the PMH team in a coordinated and collaborative effort to engage, encourage, and support patient health.

| | Skills | Responsibilities | Activities |
|---|---|---|---|
| **EMR/data management** | | | |
| **EMR data standardization** | • Demonstrates a high level of EMR knowledge and skill to ensure accuracy of data and best practices in the EMR | • Support panel cleanup, panel maintenance, and validation rate monitoring as it relates to PMH projects<br>• Ensure all patient records are kept up to date so physicians can accurately identify patient populations | • Maintain the physician's panel according to their parameters (using EMR queries to identify active panel); coordinate with physician and clinic staff<br>• Identify missing vitals, lab results, screening, referrals to external organizations, etc.<br>• Ensure results of recent tests and procedures are available to providers (e.g., information available on Alberta Netcare)<br>• Flag patient charts for physicians and clinic staff to notify them of specific actions to be taken (e.g., opportunistic screenings due)<br>• Create templates in the EMR outlined in a PMH project (i.e., templates to help improve data standardization) |

| Skills | | Responsibilities | Activities |
|---|---|---|---|
| **EMR data extraction** | • Exhibits the ability to extract, audit, and monitor PMH projects | • Ensure data extracted from the EMR is accurate<br>• Support the facilitation of discussions with physicians using PMH dashboards | • Extract core data on a quarterly basis<br>• Extract ad hoc data required to identify patient populations outlined in a PMH project (e.g., diabetic population, patients due for screenings)<br>• Save data extracted from the EMR for PMH projects in Excel/Open Office and onto secure, encrypted USB<br>• Review and audit extracted EMR data<br>• Upload data using CWC PCN file transfer protocol using secure, encrypted USB<br>• Support creation of, and assist with, presenting/describing results of PMH dashboards and reporting tools<br>*Dashboards visualize patient populations and data extracted from EMRs (e.g., diabetic population, patients with hypertension, patients due for screenings, etc.)*<br>• Support the maintenance of ongoing project monitoring tools such as run charts<br>• Support the collection of data as required (e.g., patient validation rates, Third Next Available Appointment, patient experience surveys, etc.)<br>• Assist and collaborate with Lead Measurement Consultant to gather feedback about EMR data accuracy |

| Skills | | Responsibilities | Activities |
|---|---|---|---|
| **Implementation of PMH projects** | | | |
| **Improvement project implementation** | • Demonstrates understanding, planning, and maintenance for each PMH project being undertaken to support the PMH | • Support the implementation of PMH projects (i.e., project management)<br>• Build and nurture relationships with PMH team members, physicians, clinic management, and staff | • Assist in identifying potential QI projects and working with the physician to determine a plan for implementation<br>• Track QI project progress in Monday.com — these reports can be used by physicians to support in tracking PPIP activity progress<br>• Manage list of tasks and action items related to PMH projects, including task follow-up for ongoing project progression<br>• Schedule PMH meetings with the PMH team, including the physicians and clinic staff, when appropriate (e.g., in person, virtual, combination)<br>• Schedule time with physicians and clinic staff to meet and collaborate on PMH improvement projects on a routine basis (e.g., in person, virtual, combination)<br>• Create and maintain accurate notes about PMH projects (e.g., meeting agenda development/dissemination, meeting minutes, ad hoc patient list requests, etc.)<br>• Collaborate with PMH team to support project adaptation and progression based on monitoring results |

# Patient Care Coordinator role profile

The Patient Care Coordinator (PCC) is an integral and active member of the CWC PCN's PMH team and functions remotely to support physician members in building and sustaining their medical home. This role primarily supports physicians and PMH team members implement PMH goals by focusing on the coordination of patient care and outreach to improve overall patient outcomes.

The PCC will work in conjunction with the remote Health Information Coordinator and with members of the PMH team in a coordinated and collaborative effort to engage, encourage, and support patient health.

| | Skills | Responsibilities | Activities |
|---|---|---|---|
| **Coordination of patient care** | | | |
| **Coordination of patient care** | • Ability to effectively communicate and work with all members of the PMH team in a coordinated and collaborative effort to engage, encourage, and support patient health | • Ensure the right patient is provided care by the right provider at the right time<br>• Support the coordination of patient care aimed at improving overall patient outcomes within the PMH<br>• Support the coordination of patient care to the medical neighbourhood (outside of the PMH) | • Perform outreach to patients identified in PMH projects (e.g., call patients to have a diabetic foot exam with Primary Care Registered Nurse)<br>• Develop and use scripts to discuss reason for call and reason for visit with the specified regulated health professional<br>• Coordinate patient care to appropriate PMH team member, including referral processing, ensuring patient is informed about appointment information, and providing appointment reminders<br>• Provide further instructions or information as required to patients prior to the visit (e.g., forms to be completed prior to appointment)<br>• Ensure notes are recorded in the EMR for physicians and clinic staff knowledge |

| Skills | | Responsibilities | Activities |
|---|---|---|---|
| **Panel management, EMR standardization** | | • Ensure all patient records are kept up to date<br>• Act as CII/CPAR panel administrator, unless panel is managed by clinic | • Coordinate patient care by referral to the medical neighbourhood (i.e., patients identified in projects that require care outside of the PMH)<br>• Support routine panel maintenance and patient validation processes (i.e., confirming primary provider, demographics, and validating patient information while performing outreach to patients)<br>• Identify missing vitals, lab results, or screening, referrals to external organizations, etc. (e.g., checking Alberta Netcare for missing results prior to contacting patients)<br>• Ensure results of recent tests and procedures are available to providers (e.g., information available on Alberta Netcare)<br>• Schedule time that is feasible for physicians and clinic staff to meet and collaborate on PMH projects on a routine, ongoing basis (e.g., in person, virtual, combination)<br>• Record progress of QI projects in Monday.com |

# Quality Improvement Consultant role profile

The Quality Improvement Consultant (QIC) is an integral and active member of the CWC PCN's PMH team. The QIC supports physicians and PMH team members in the implementation of quality improvement (QI) projects by facilitating teams through improvement processes to help build and sustain medical homes. The QIC works closely with the PMH team members to build QI capacity through mentorship and coaching.

| | Skills | Responsibilities | Activities |
|---|---|---|---|
| **Building QI capacity in the PMH team** | • Knowledgeable about quality improvement methodology<br>• Able to apply QI knowledge in a variety of environments<br>• Able to teach others about QI methodology theory and apply it in a primary care setting | • Develop educational materials for other team members to build their knowledge and awareness of QI methodologies and processes in the primary care environment<br>• Collaborate with clinicians to help team members understand how QI is implemented in primary care<br>• Help team members understand the approach that the CWC PCN uses to facilitate change toward creating medical homes | • Present at staff meetings and lead workshops to support QI capacity building<br>• Ongoing mentorship within PMH teams<br>• Develop QI materials as required |

| | Skills | Responsibilities | Activities |
|---|---|---|---|
| **Facilitate improvement processes** | • Facilitate PMH teams to identify and implement projects that support patient care | • Build strong relationships with PMH teams (physicians, Primary Care Registered Nurses, Primary Care Registered Psychologists, Patient Care Coordinators, Health Information Coordinators, and clinic office staff)<br>• Facilitate conversation in teams to initiate PMH goals<br>• Work closely with PMH team to identify potential patients that would benefit from planned care<br>• Collaborate with the PMH team to identify patient outcomes based on improvement goals | • Be present at PMH meetings when appropriate to facilitate project work<br>• Support team with QI tools that will help determine improvement approach<br>• Guide PMH team to identify appropriate outcomes (both process and patient outcomes)<br>• Guide PMH team to plan, document, and monitor progress |
| **Project management** | • Oversee the planning and maintenance of improvement projects implemented by physician members | • Ensure tasks outlined in improvement goals are completed on time<br>• Ensure process and outcomes are documented, monitored, and reported<br>• Ensure all improvement projects are documented and tracked appropriately (including goals and specific tasks that are included in the improvement plan) | • Keep team aware of timelines<br>• Monitor data to track progress and identify improvement opportunities<br>• Monitor project progress |

| | Skills | Responsibilities | Activities |
|---|---|---|---|
| **Data analysis and interpretation** | • Able to interpret EMR data to support clinicians in decisions about care planning | • Able to describe and interpret reports (e.g., describing a panel population)<br>• Support PMH teams with data use for goals surrounding specific patient groups<br>• Provide analytic support to teams within clinics (e.g., supporting teams to monitor progress through run charts, etc.) | • Simplify and process data to create analytic reports<br>• Remove patient identifiable information from reporting<br>• Present EMR reports (e.g., panel, discovery, specific improvement reports that show change)<br>• Analyze EMR data<br>• Assist in the creation of analytic reports as a decision-support tool using EMR data |

# Social Worker role profile

The CWC PCN Social Worker team is part of the Mental Health Program and, as such, report to the program's manager. Social Workers provide assessment and treatment and the provision of services to patients of all ages. This may include psychosocial assessment, crisis management, resource counseling, case coordination, transition planning, and advocacy according to professional practice standards. Social Workers recommend and facilitate applications and referrals to government and community agencies based on patient needs and agreed-upon goals. This can include, but is not limited to:

- Basic needs
- Emergency support
- Disability supports and programming
- Mental health system navigation and supports
- Family mediation and domestic violence intervention
- Caregiver and family supports
- Housing
- Transportation
- Recreation
- Medical equipment and coverage
- Financial support and benefits

The Social Worker team accepts referrals from physician members as well as CWC PCN regulated health professionals. Assistance is provided in the short-term to help link patients with community supports and agencies rather than long-term case management. If patient needs are assessed to be more complex, the Social Worker may remain involved on a medium-term basis while longer-term support is arranged.

| Skills and responsibilities | Activities |
|---|---|
| • Experienced in addressing a broad continuum of patient needs and concerns across the entire lifespan<br>• Assists patients and families to address the impact of complex health issues and life stressors<br>• Considers the social determinants of health, biopsychosocial, and cultural needs of the patient, family, and their support systems<br>• Assesses and understands healthcare system and community factors impacting patient health<br>• Connects patients to community resources and agencies<br>• Provides accessible, patient-centred care<br>• Committed to the importance of early intervention, prevention, and health promotion<br>• Addresses barriers to well-being and supports improvement in social functioning<br>• Works to improve social functions through referrals, connecting patients to resources and advocating for access to resources and supports | *Comprehensive assessment*<br>• Conducts comprehensive social work assessment, intervention, and consultation in accordance with evidence-based and professional standards of practice<br>• Facilitates crisis management, planning, and intervention<br>• Provides an interpretation of assessment findings and treatment recommendations to patient, family members, other caregivers, and educators<br>*Case coordination*<br>• Creates care plans based on the patient's unique needs<br>• Supports semi-urgent referrals for short-term case coordination<br>*Resource counseling*<br>• Facilitates referrals to and liaises with community resources and health services to support coordinated referrals<br>• Provides information and access to health, recreational, community, and government resources<br>*Care delivery*<br>• Conducts care virtually (phone or video calls), in the patient's home, or at the clinic, as appropriate and based on patient need<br>• Collaborates with interdisciplinary colleagues to support physician referral, recommendations, and consultation, including regular case consultation as needed<br>• Participates in ongoing quality improvement activities, program development, and evaluation projects<br>• Conducts ongoing research for appropriate supports and services, community linkage, and program development |

# Registered Nurse - Senior Services role profile

| | Skills and responsibilities | Activities |
|---|---|---|
| **Patient care** | *Chronic disease focus*<br>• COPD, chronic pain, congestive heart failure, chronic kidney disease, diabetes, dyslipidemia, gastrointestinal issues (IBS, GERD, dyspepsia), hypertension, multi-complexities, neurodegenerative disorders, obesity, obstructive sleep apnea<br>*Geriatric assessments/cognition*<br>• Comprehensive geriatric assessments<br>• Completes cognitive screening: MMSE, SLUMS, TRAILS (A/B), RUDAS, Zarit Burden Interview, and Functional Activities<br>*Caregiver support*<br>• Resource navigation, counselling, validation<br>*Addictions cessation*<br>• Offers ram reduction support, education, and linkages to programs for patients (Substance Abuse in Later Life)<br>*Mental health screening and interventions*<br>• Provides general assessment utilizing evidence-informed tools: PHQ9, GAD7, and GDS<br>• Provides support, behavioural interventions, education, resources, and referrals when appropriate | *Provides: assessment, screening, healthy lifestyle support, education, chronic disease management, and mental health support*<br>• Supports patients to improve health outcomes and assists them in understanding and accessing additional programs and services<br>• Performs initial and ongoing nursing assessments of patients within the framework of professional nursing practice and the principles of primary health care with a focus on seniors' health<br>• Develops and implements patient-centred reports in collaboration with the patient, their care team, and their caregivers to ensure continuity of care<br>• Provides care recommendations and referrals back to the physician and follow up with patient, as needed<br>• Provides condition-specific patient education and support with development of technical skills needed for self-management (e.g., BP/BG monitoring) utilizing medically evidence-informed best practice standards (e.g., CPGs, enhanced clinical pathways)<br>• Provides referrals and linkages to approved community and online programs (e.g., Alberta Healthy Living Program, Alzheimer's Society, Caregivers Alberta, Home Care, etc.) |

| | Skills and responsibilities | Activities |
|---|---|---|
| | *Mobility*<br>• Falls, physical activity modifications, assistive devices, Parkinson's, and other movement disorders<br>*Best possible medication history*<br>• Works with patients to create a complete, accurate, and up-to-date medications list<br>*Social history*<br>• Understands patients' histories to better diagnose the impact of cognitive decline<br>*Advanced care planning*<br>• May initiate and undertake Advance Care Planning and/or Goals of Care Designation conversation (including Green Sleeve education); however, the most responsible practitioner is ultimately responsible for ensuring that a clinically indicated Goals of Care Designation order has been discussed, established, and documented | • Conducts geriatric assessments to determine status and appropriate next steps for care<br>• Conducts an ERA and determines the appropriateness of home visits or clinic visits for the patient<br>• Provides patients and caregivers with resources specific to their needs |
| **Person-centred care** | • Utilizes HealthChange Methodology to provide person-centred care and promote health literacy, shared decision-making, behaviour change, and self-management to support adherence to evidenced-based recommendations for improved health and quality of life outcomes | • Apply HealthChange Methodology to support patients in self-managing their health conditions |

| | Skills and responsibilities | Activities |
|---|---|---|
| **Quality improvement** | • Develops an understanding of and applies the principles of quality improvement in the provision of care<br>• Able to participate in and initiate improvement processes within primary care that support improving patient care<br>• Supports and mentors PMH team members and colleagues in the principles of quality improvement<br>• Able to use data to inform decisions about improving patient care both at the patient population and individual care level | • Collaborates with the PMH team to identify patient groups and improvement goals to improve patient care<br>• Works with the PMH team to create care plans for chronic disease patients<br>• Works with the PMH team to coordinate comprehensive screening for health issues<br>• Monitors changes over time as a result of improvement goals<br>• Documents improvement goals, expected outcomes, and collects relevant information to inform change<br>• Participates in measuring patient outcomes |

# Primary Care Regsitered Dietitian role profile

The CWC PCN Primary Care Registered Dietitian team is part of the Community Services, Transitions, and Innovations (CSTI) priority area and, as such, report to the Manager of Community Services and Care Transitions.

Primary Care Registered Dietitian's provide assessment and treatment and the provision of services to patients aged 10 and up. This may include case coordination, meal planning, reviewing needs and goals, transition planning, and support.

Primary Care Registered Dietitian's recommend and support care plans and develop strategies to manage diet and health as it relates to the patient's referral reason while considering concurrent conditions as they exist.

Primary Care Registered Dietitians focus on the following referral-sourced conditions:

- Irritable bowel syndrome (IBS)
- Crohn's disease
- Ulcerative colitis
- Celiac disease
- Liver health
- Kidney health

The Primary Care Registered Dietitian team accepts referrals from physician members as well as CWC PCN regulated health professionals.

| | Skills and responsibilities | Activities |
|---|---|---|
| **Patient care** | • Experienced in addressing a broad continuum of patient needs and concerns across the entire lifespan<br>• Assists patients to address the impact of complex health issues and life stressors<br>• Considers the social determinants of health, biopsychosocial, and cultural needs of the patient, and their support systems<br>• Assesses and understands healthcare system and community factors impacting patient health<br>• Connects patients to community resources and agencies<br>• Provides accessible, patient-centred care<br>• Committed to the importance of early intervention, prevention, and health promotion<br>• Addresses barriers to well-being and supports improvement in social functioning<br>• Works to improve health and diet functions through referrals and connecting patients to resources | *Comprehensive assessment*<br>• Conducts comprehensive dietary assessment, intervention, and consultation in accordance with evidence-based and professional standards of practice<br>• Facilitates diet and health management as it relates to referral reason<br>• Provides an interpretation of assessment findings and treatment recommendations to patient<br>*Case coordination*<br>• Creates care plans based on the patient's unique needs<br>• Provides internal and external collaboration and referrals as needed<br>*Care delivery*<br>• Conducts care virtually (phone or video calls)<br>• Collaborates with interdisciplinary colleagues to support physician referral, recommendations, and consultation, including regular case consultation as needed<br>• Participates in ongoing quality improvement activities, program development, and evaluation projects<br>• Conducts ongoing research for appropriate supports and services, community linkage, and program development |

# Physiotherapist role profile

The CWC PCN's Physiotherapists are part of the Community Services, Transitions, and Innovations (CSTI) priority area and, as such, report to the Manager of Community Services and Care Transitions. Physiotherapists provide assessment services, referrals to third-party providers, access to resources, and self-management programming using the online platform Wibbi.

CWC PCN Physiotherapists focus on the following referral-sourced conditions that limit physical activity, pain, or range of motion.

**Inclusion criteria:**

- The patient requires physical rehabilitation and/or pain management and can actively participate in physio to achieve a positive outcome.
- The patient is motivated and willing to participate in either one-on-one or group exercise settings and perform a home exercise program.

**And one of the following criteria are met:**

- Rotator cuff related **shoulder pain** that limits activity and participation in the community.
- Joint related degenerative **hip and/or knee pain** due to osteoarthritis that limits activity and participation in the community

The Physiotherapy Program and Physiotherapists accepts referrals from CWC PCN physician members.

| | Skills and responsibilities | Activities |
|---|---|---|
| **Patient care** | • Experienced in addressing a broad continuum of patient needs and concerns across the entire lifespan<br>• Assists patients to address the impact of complex health issues and life stressors<br>• Considers the social determinants of health, biopsychosocial, and cultural needs of the patient, and their support systems<br>• Assesses and understands healthcare system and community factors impacting patient health<br>• Connects patients to community resources and agencies<br>• Provides accessible, patient-centred care<br>• Committed to the importance of early intervention, prevention, and health promotion<br>• Addresses barriers to well-being and supports improvement in social functioning<br>• Works to improve health and diet functions through referrals and connecting patients to resources | *Comprehensive assessment*<br>• Conducts comprehensive assessment, intervention, and consultation in accordance with evidence-based and professional standards of practice<br>• Facilitates health management as it relates to referral reason<br>• Provides an interpretation of assessment findings and treatment recommendations to patient<br>*Case coordination*<br>• Creates care plans based on the patient's unique needs<br>• Provides internal and external collaboration and referrals as needed<br>*Care delivery*<br>• Conducts care virtually (phone or video calls)<br>• Collaborates with interdisciplinary colleagues to support physician referral, recommendations, and consultation, including regular case consultation as needed<br>• Participates in ongoing quality improvement activities, program development, and evaluation projects<br>• Conducts ongoing research for appropriate supports and services, community linkage, and program development |