Our Vision:
A community of family physicians and primary care providers building collaborative, integrated, and innovative medical homes, responsive to the needs of our population.

Our Mission:
1. To serve our communities
2. To promote best practice primary health care and family medicine
3. To enable our members to build and support patient-centred medical homes
4. To translate innovations in family medicine to our physicians and communities
5. To support medical education, credentialing, recruitment and retention
Executive Summary
EXECUTIVE SUMMARY

The Department of Family Medicine consists of 1094 family physicians with a Medical Staff Appointment with 63 new appointments in 2014-2015. The Academic DFM has 688 family physicians with an Academic Appointment with 175 new appointments approved this year.

ACCOMPLISHMENTS & HIGHLIGHTS

CLINICAL DFM

The Clinical DFM finalized their Strategic Plan for 2015-2018 with a number of 12 month and 3 year goals based on four pillars of the Medical Home: System Supports, Evaluation, Education Training and Research, and Continuity of Care.

Maternal Newborn Care

- There were 18,471 deliveries in the Calgary Zone from Dec 1, 2013 – Nov 30, 2014. Family physicians were responsible for 46.66% of admissions to Labour and Delivery Units and 33.90% of Calgary hospital deliveries.
- The section focused this year on enhancing physician engagement in a variety of different ways with an emphasis on quality activities. A communication survey was distributed within the section with results influencing communication strategies throughout the DFM.
- A successful Collaborative Care Project was initiated this year using the Obstetrical Consultation and Transfer of Responsibility Standard of Practice and the Care of Women who are Appropriate for Vaginal Birth after Caesarean Section (VBAC) Protocol. A VBAC audit was conducted in early 2014 with general agreement that the protocol is effective.
- Other successes included the roll-out of an electronic process for physicians to complete their periodic reviews which was enthusiastically adopted by the Seniors Care, Palliative Care, and Community Primary Care sections.

Medical Inpatient Care

- Hospitalists admitted 13,229 patients (excluding RAU admissions) and attended patients for 268,298 days between Jan to Dec 2014.
- Results from the evaluation of the Rapid Access Unit (RAU) at the South Health Campus demonstrate that the RAU is significantly reducing patient’s stay an average of 44 hours, discharging twice as many patients home within 48 hours and reducing overall length of stay by 36% without increasing readmission rates.
- The use of anti-psychotic, sedative and anxiolytic medications amongst seniors is prevalent without clear evidence based justification for efficacy and safety. The B-SAFE project evaluated the prevalence of these medications before, during and immediately after and admission to a Calgary acute care hospitalist service. Individualized patient reports are developed allowing physicians to better understand use of these medications, reflect upon possible changes and consider participating in an educational and/or clinical intervention.
EXECUTIVE SUMMARY

Urgent Care

- The five urgent care centres in the Calgary Zone saw 182,692 patients in 2014. Volumes, specifically at the Sheldon Chumir have had a marked increase since 2013, averaging approximately 156 patients per day. Acuity has also increased throughout all sites.
- The section has been successful in implementing approximately 95% of the Urgent Care Review report including reviewing documents reflecting optimization of urgent care services, developing competencies for urgent care physicians and providing monthly data for all UCCs on volume, acuity, LWBS and transfer information.

Palliative Care

- Demand for palliative care has resulted in the Section providing care to 3880 unique patients.
- On April 1, 2014 a new Level 1 AHS policy and procedure for Advanced Care Planning and Goals of Care Designation (ACP GCD) was implemented across Alberta with representatives from the section contributing to the policy and preparation of “toolkits” for physicians.
- The Intensive Palliative Care Unit increased from 21 to 29-31 beds in late 2013. For the 2013-14 fiscal year 618 patients were admitted to the unit.
- Starting in the summer of 2014 the section has established a dedicated palliative consult presence at the Tom Baker Cancer Centre. This represents an expansion of the previous TBCC Pain and Symptom Management Clinic’s scope and allows palliative expertise five days a week.

Seniors Care

- Alberta Health approved an expansion to the Frail Elderly ARP as of Aug 2014. It included an additional 14 Long Term Care and 7 Supportive Living sites. To date, recruitment efforts have been successful for these positions.
- The Community Paramedic Program will expand into Long Term Care sites in 2015. The section also hopes to expand the awareness of the program amongst family physicians in the community.

Community Primary Care

- The DFM partnered with the PCN Secretariat to develop a Physician Web Registry that includes up to date contact information for family physicians for use by health professionals in the Calgary Zone.
- Based on its success in providing up to date admission and discharge notifications to physicians in the community the Path to Home Discharge Pilot Project at the Foothills Hospital has moved beyond the pilot.
- The launch of the GI Specialist Link with a GI specialist returning family physician inquiries within 30 minutes Monday to Friday has received over 67 calls in the first three months. More specialty linkages are being forged to expand the service.
EXECUTIVE SUMMARY

ACADEMIC DFM

The Academic DFM underwent a program-wide accreditation conducted by the College of Family Physicians of Canada (CFPC). The programs will continue to implement the recommendations from review and prepare for their next round of accreditation.

Undergraduate Education

- 95% of incoming medical students participated in MedZero this last year. Clinical preceptors helped deliver the ever-popular hands on workshops in casting and suturing.
- This year’s clerkship class ranked family medicine at the top! The program is beginning to experience success with the “Morning Star” or patients as teachers program.

Postgraduate Education

- As of March 31, 2015 the number of residents in the 2 year program totaled 157.
- In 2014 the program graduated its first group of Triple C- Competency based residents. Of the group of 113 residents 78 were from the Urban Program, 14 from the Rural Program and 21 from the Enhanced Skills Program.
- In the Enhanced Skills Program there were 11 Category 1 and 7 Category 2 R3 residents in 2013-2014. These numbers will increase to 14 R3s in Category 1 and 7 Category 2 in 2014-15.
EXECUTIVE SUMMARY

CHALLENGES

CLINICAL DFM

Maternal Newborn Care

- One of the key challenges for the section was the Maternal Child Volume Redistribution discussions which will continue throughout 2015. DFM physicians have collaborated in discussions at each site to develop key strategies to assist with capacity issues.
- The section has recognized the need to clearly outlining privileging processes for locums. Work continues with the DFM to ensure locums are privileged correctly.

Medical Inpatient Care

- The gap between population need for facility-based community care and physical availability of appropriate spaces continues to be a challenge. On a daily basis, patients awaiting placement account for up to 1/3 of the total patient census.

Urgent Care

- Increased acuity and number of patients at both urban urgent cares continues to present challenges for providing patient care.
- The annual Urgent Care Conference has been put on hold due to increased event costs.

Palliative Care

- Recruitment challenges to all funded positions of the clinical ARP continue. Many physicians have had to work more hours than their contracted amounts in order to ensure palliative care service is always staffed.

Seniors Care

- Recruitment of physicians to provide onsite care in supportive living sites for those patients who do not have a family physician remains a challenge.
- The issue of access to Netcare for physicians’ onsite at supportive living and continuing care sites creates a barrier to continuity of care. This issue has been escalated and will be addressed at a senior administrative level within AHS.

Community Primary Care

- It is important to understand the various ways that patients seek and receive medical care. With this in mind, we are trying to understand how many patients are truly "unattached" and the factors that come in to play that lead patients to not "attach" to a medical home.
- The section continues to look at medical home model with a lot of work is being done in the area of Panel Identification in family practices. Challenges continue in providing patients with 24/7 care within the medical home.
EXECUTIVE SUMMARY

- Specialty linkages and long wait times for patients to be seen by specialists also continues to be a challenge in the Calgary Zone. With this in mind, Primary Care and Specialist groups are collaborating to look at innovative ways to meet some of these needs.

ACADEMIC DFM

Undergraduate Education

- Recruitment of experienced academic physicians with undergraduate focus and experience remains a challenge.
- Competing demands on academic physician time including the necessity of scholarly input for academic physicians in administrative roles continues.

Postgraduate Education

- Rapid growth has posed a challenge for the program. Challenges for the urban program has caused strain in the capacity for quality learning experiences, preceptor-resident ratios; capacity for remediation of residents and reduction of potential transfers from other programs.
FUTURE DIRECTIONS

CLINICAL DFM

Maternal Newborn Care

- The section will continue its quality initiatives as a key focus for the upcoming year. In addition we are looking at how to enhance referral guidelines and the optimal route for communicating this information. Ongoing work will occur to ensure alignment of the Volume Redistribution Working Group.

Medical Inpatient Care

- Future initiatives including geographic rounding, antimicrobial stewardship, physician leadership development, implementation of the electronic periodic review process, and strengthening academic linkages.

Urgent Care

- Work continues on the implementation of the Urgent Care Review report recommendations.

Palliative Care

- The Supreme Court of Canada decision that has allowed for the possibility of “Physician Assisted Death” has implications on the section. Collaborative discussions have begun within the section and with AHS.

Seniors Care

- Through the Seniors SCM, the Seniors section is currently involved in the Primary Care Working Group for the development of a provincial dementia strategy.

Community Primary Care

- The section continues to look at ways of trying to improving communication, particularly during transitions in and out of the Medical Home. It is recognized that this communication is key to patients receiving quality, timely and safe patient care.

ACADEMIC DFM

Undergraduate Education

- The U of C Cumming School of Medicine accreditation is scheduled for 2016 with mock accreditation scheduled for Sept 2015. The program is currently working on preparing for these activities.

- Ongoing initiatives including MedZero, MDCN 400 Family Medicine Research Developing Program, the Morning Star Program and community engagement activities are part of our future.
执行摘要

研究生教育

- 该计划正在进行多项举措，包括：2015年秋季对城市住院医师项目进行重大课程审查；开发结构化的临产和新生儿护理增强技能课程；以及继续提供“家庭教室系列”教师发展研讨会，为家庭医学教学诊所提供教师发展工作坊。
The DFM has embraced the ten pillars of the medical home as the model for primary care. Icons with a pillar of the medical home are placed throughout our accomplishments highlighting examples of how we are operationalizing this model. An index of these examples can be found in the Appendix of this report.
Departmental Structure & Organization
DEPARTMENTAL STRUCTURE AND ORGANIZATION

GOVERNANCE

CLINICAL DEPARTMENT – EXECUTIVE COMMITTEE

Dr. Michael Spady  Acting Zone Clinical Department Head
Dr. Charles Leduc  Academic Department Head
Mr. Rod Iwanow  Department Manager

Dr. Monica Sargious  Section Chief, Community Primary Care
Dr. Norma Spence  Section Chief, Maternal Newborn Care
Dr. Jim Eisner  Section Chief, Medical Inpatient Care
Dr. Lindy Murphy  Section Chief, Palliative Care (until October 2014)
Dr. Ayn Sinnarajah  Section Chief, Palliative Care (starting November 2014)
Dr. Marie Patton  Section Chief, Seniors Care
Dr. Tyson Warner  Section Chief, Urgent Care (until February 2015)
Dr. Matthew Hall  Section Chief, Urgent Care (starting April 2015)
Dr. Rick Ward  Medical Director, Primary Care

Ms. Kim Kiyawasew  Community Practice Consultant
Ms. Judy Schoen  Hospitalist Specialist
Ms. Darlene Befus  Physician Recruitment Coordinator
Ms. Danica Sharp  Service Planning Consultant, Maternal Newborn Care

ACADEMIC DEPARTMENT – LEADERSHIP

Dr. Charles Leduc  Academic Department Head
Dr. David Keegan  Deputy Department Head; Director, Undergraduate Education
Dr. Keith Wycliffe-Jones  Director, Post-Graduate Education
Dr. Dennis Kreptul  Interim Director, Patient Centred Medical Home & QI
Dr. Turin Chowdhury  Director, Research
Dr. Sonya Lee  AARP Management Committee Chair
Dr. Ron Spice  Director, Rural Academics
Dr. Juan Garcia-Rodriguez  Director, Continuous Professional Development
Dr. Todd Hill  Director, Behavioural Medicine
Dr. Mone Palacios  Medical Education Specialist
Dr. Steve Mintsioulis  Urban Program Director
Dr. Rick Buck  Rural Program Director
Dr. Lara Nixon  Enhanced Skills Program Director
Dr. Martina Kelly  Clerkship Director
Dr. Behi Raissi  Site Medical Lead (Central Teaching Clinic)
Dr. Sonya Lee  Site Education Lead (Central Teaching Clinic)
Dr. Ron Garnett  Site Medical Lead (South Health Campus Teaching Clinic)
Dr. Divya Garg  Site Education Lead (South Health Campus Teaching Clinic)
Dr. Wes Jackson  Site Medical Lead and Interim Site Education Lead (Sunridge)
DEPARTMENTAL STRUCTURE AND ORGANIZATION

Mr. Rod Iwanow  
Department Manager
Ms. Jeanine Robinson  
Education Manager
Mr. Scott Jalbert  
Clinic Manager (Central Teaching Clinic)
Ms. Jane Bowman  
Clinic Manager (South Health Campus)
Ms. Nicole Phillips  
Clinic Manager (Sunridge)

DEPARTMENTAL COMMITTEES

CLINICAL DFM
DFM Executive Committee
DFM Obstetrics Site Leads Committee
DFM Clinical Administration Committee
DFM Clinical Managers Team
DFM Communications

ACADEMIC DFM
AARP Management Committee  
Leadership Team
Academic Business Committee  
Postgraduate Executive Committee
CARMS Selection Committee  
Postgraduate Medical Education Committee
Clerkship Committee  
Rural Family Medicine Residency Program
Clinic Management Team  
Committee
Clinic Operations Team  
Scholarship Committee
Clinic Education Committee  
Search & Selection Committee
Continuous Professional Development Committee  
Undergraduate Family Medicine Education Committee
Curriculum and Evaluation Committee  
Committee
Education Committee  
Urban Curriculum and Evaluation Committee
EMR Steering Committee  
Urban Family Medicine Residency Program
Enhanced Skills Program Committee
Committee
DEPARTMENTAL STRUCTURE AND ORGANIZATION

MEMBERSHIP

CLINICAL DFM

The number of Medical Staff Appointments continues to grow every year with the past five years demonstrating the greatest growth in the family physician workforce in the Calgary zone.

![DFM Medical Staff Appointments 2010-2015](chart)

1001 family physicians hold a primary appointment with the DFM with another 93 physicians holding a supplementary appointment with a primary in another clinical department. The majority of physicians hold both a primary and one or more supplementary appointments in our clinical sections with most physicians holding an appointment in Community Primary Care.

<table>
<thead>
<tr>
<th>Medical Staff Appointments as of April 28, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Maternal Newborn Care</td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>Primary DFM Privileges</td>
</tr>
<tr>
<td>Supplementary DFM Privileges</td>
</tr>
<tr>
<td>Total Primary &amp; Supplementary Privileges</td>
</tr>
</tbody>
</table>
DEPARTMENTAL STRUCTURE AND ORGANIZATION

New Medical Staff Appointments
63 family physicians were newly appointed to the DFM in 2014-15.

<table>
<thead>
<tr>
<th>New Primary Appointment</th>
<th>45</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Supplementary Appointment</td>
<td>7</td>
</tr>
<tr>
<td>Change Primary Appointment</td>
<td>8</td>
</tr>
<tr>
<td>to DFM from Another Clinical</td>
<td></td>
</tr>
<tr>
<td>Department in Calgary Zone</td>
<td></td>
</tr>
<tr>
<td>Transferred from Another AHS</td>
<td>3</td>
</tr>
<tr>
<td>Zone</td>
<td></td>
</tr>
</tbody>
</table>

Retirement and Resignations
19 physicians resigned their Medical Staff Appointments with the DFM in 2014-2015. Reasons for termination of clinical privileges are listed below.

<table>
<thead>
<tr>
<th>Resignation (including relocation)</th>
<th>15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retired</td>
<td>3</td>
</tr>
<tr>
<td>Deceased</td>
<td>1</td>
</tr>
<tr>
<td>Moved Primary Appointment</td>
<td>1</td>
</tr>
<tr>
<td>to Another Clinical Department</td>
<td></td>
</tr>
</tbody>
</table>
DEPARTMENTAL STRUCTURE AND ORGANIZATION

ACADEMIC DFM

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of DFM Academic Appointments</td>
<td>688</td>
</tr>
<tr>
<td>Total Number of New Appointments</td>
<td>175</td>
</tr>
<tr>
<td>Full Time Academics (FTAs)</td>
<td>21</td>
</tr>
<tr>
<td>Major Clinicals</td>
<td>7</td>
</tr>
<tr>
<td>Major Clinical Academics (MCAs)</td>
<td>6</td>
</tr>
</tbody>
</table>

Faculty

Central Teaching Centre
- Dr. Jim Dickinson
- Dr. David Keegan
- Dr. Martina Kelly
- Dr. Dennis Kreptul
- Dr. Patrick Lee
- Dr. Sonya Lee
- Dr. Kerry McBrien
- Dr. Doug Myhre
- Dr. Lara Nixon (The Alex)
- Dr. Maeve O’Beirne (sabbatical)
- Dr. Roger Thomas
- Dr. David Topps
- Dr. Maureen Topps

SHC Teaching Centre
- Dr. Ron Garnett

Sunridge Teaching Centre
- Dr. Fariba Aghajafari
- Dr. Heather Armson
- Dr. Juan Garcia-Rodriguez
- Dr. Wes Jackson
- Dr. Keith Wycliffe-Jones

Other
- Dr. Lindsay Crowshoe (Elbow River Healing Lodge)
- Dr. Ron Spice

Major Clinical Academics (MCAs)
- Dr. Jean Rawling
- Dr. Wendy Tink

- Dr. Vishal Bhella
- Dr. Divya Garg

- Dr. Johan Bester
- Dr. Shashank Garg
DEPARTMENTAL STRUCTURE AND ORGANIZATION
DEPARTMENTAL STRUCTURE AND ORGANIZATION

Academic Department Organizational Chart
Department of Family Medicine

Head Academic Department
Charles Leduc

Deputy Head Academic Department
David Keegan

Director Undergraduate Education
David Keegan

Director Postgraduate Education
Keith Wycliffe-Jones

Director Research
Turin Chowdhury

Director Patient-Centred Medical Home & QI
Dennis Kroplin (Interim)

Director Rural Academics
Ron Spice

Director Behavioural Medicine
Todd Hill

Chair, AARP Management Committee
Sonya Lee

Director CPD
Juan Antonio Garcia

Specialist Medical Education
Mone Palacios

Manager Academic Department
Rod Iwanow

Manager Education
Jeanine Robinson

Manager Central Teaching Centre
Scott Jalbert

Manager South Health Campus Teaching Centre
Jane Bowman

Manager Sunridge Teaching Centre
Nicole Phillips

Lead Clinical Informatics
Chris Diamant

Consultant Academic Service Planning
Allison Mirochnik

Coordinator Clinical Informatics & Training
Carol Hort

Consultant Special Projects & Innovation
Dave Jackson

Senior Analyst Finance
Jesse Walper

Coordinator Contracts
Sharmina Dharsee

Financial Administrative Assistant
Lori Trieu

Associate Quality Improvement
Lucie Vlach

Senior Administrative Assistant
Karen Anderson (Interim)
Megali Leong (LOA)

Manager Central Teaching Centre (Interim)
Scott Jalbert

Manager Sunridge Teaching Centre
Nicole Phillips

Consultant Academic Service Planning
Allison Mirochnik

Lead Clinical Informatics
Chris Diamant

Coordinator Clinical Informatics & Training
Carol Hort

Senior Analyst Finance
Jesse Walper

Coordinator Contracts
Sharmina Dharsee

Financial Administrative Assistant
Lori Trieu

Associate Quality Improvement
Lucie Vlach

Senior Administrative Assistant
Karen Anderson (Interim)
Megali Leong (LOA)
DFM Strategic Plan
The Executive Committee ratified the Vision, Mission and Strategic Pillars for the DFM that were a result of the first series of strategic planning exercises in 2014. To further their work they further engaged in strategic planning exercises in the winter of 2015 in which 12 month and 3 to 5 year goals were created using the pillars of the medical home. These goals have strengthened the direction of the Department and were approved by the Executive in February 2015.

**OUR VISION**

*A community of family physicians and primary care providers building collaborative, integrated, and innovative medical homes, responsive to the needs of our population.*

**OUR MISSION**

1. To serve our communities
2. To promote best practice primary health care and family medicine
3. To enable our members to build and support patient-centred medical homes
4. To translate innovations in family medicine to our physicians and communities
5. To support medical education, credentialing, recruitment, and retention

**STRATEGIC PILLARS**

<table>
<thead>
<tr>
<th>Operational Mandate</th>
<th>Human Resource Management</th>
<th>Collaborative Partnerships</th>
<th>Quality and Safety</th>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic Teaching Clinics</td>
<td>Credentialing and Privileging</td>
<td>Primary Care Networks</td>
<td>Patient and Staff Feedback</td>
<td>To Physicians</td>
</tr>
<tr>
<td>Maternal Newborn Care</td>
<td>Leadership Development</td>
<td>AHS Partners</td>
<td>Care Pathways</td>
<td>To Learners</td>
</tr>
<tr>
<td>Medical Inpatient Care</td>
<td>Continuing Medical Education</td>
<td>Alberta Health</td>
<td>Quality Improvement and Best Practice</td>
<td>To Department of Family Medicine Staff</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Training and Post-Graduate Education</td>
<td>Community Organizations</td>
<td>Quality Assurance Research</td>
<td>To Patients and Families</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>Recruitment and Workforce Planning</td>
<td>Strategic Clinical Networks</td>
<td></td>
<td>To Alberta Health Services Partners</td>
</tr>
<tr>
<td>Seniors Care</td>
<td></td>
<td>Patients and Families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Primary Care</td>
<td></td>
<td>Alberta Medical Association</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>College of Physicians and Surgeons of Alberta</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>University of Calgary</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alberta College of Family Physicians</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DFM STRATEGIC PLAN

DFM Medical Home Planning Model 2014-2015

Comprehensive Care Support Role
- Team based approach
- Pt. & Fam at center of all decisions
- Collaborative
- Health Promotion and Social determinants of health
- Evidence Based Care

Continuity of Care Primary Role
- Continuity of Relationships
- Coordination and continuity of information
- Pt Advocacy
- Continuity in different care settings

Support Systems Primary Role
- Leadership development
- Governance, administrative role & responsibility (Physician/Consultant support)

Team Based Care Support Role
- Collaborative
- Clearly defined roles and responsibility
- Broad scope of clinic services & Allied Health

Timely Access Support Role
- 24/7 Access
- Panel size and management
- Referrals

Personal Family Physician Support Role
- Most responsible provider
- DFM privileged

Patient Centered Support Role
- Response to Pt. needs
- Cultural advocacy
- Respect
- Active participants
- Access to information
- Self managed care through care plan

Education Training and Research
- Teaching Patient Medical Home
- Supporting Research

EMR Support Role
- Interconnected, user friendly
- Interoperable
- Secure access
- Privacy/Confidentiality

Evaluation Primary Role
- QI
- QA-Patient Safety
- Collaborative Interaction
- Patient Satisfaction
- Cost Effective

DFM Medical Home

Team Based Care

Timely Access
DFM STRATEGIC PLAN

12 MONTH GOALS (2015-2016)

PHYSICIAN SERVICES (SUPPORT SYSTEMS)

Clinical and Academic Appointment Processes

1) To work collaboratively with the Medical Affairs and the U of C to clarify roles and responsibilities and streamline departmental accountabilities and improve current Academic and clinical appointment processes within the next 12 months.

2) To develop a streamline process for providing academic appointments to family medicine physicians, to provide appointments for 100% of appropriate physicians within 12 months.

Leadership Development

1) Develop a leadership framework which addresses succession planning, mentorship, leadership training and appropriate compensation to improve the culture of leadership, and work life balance within each of the clinical sections.
   • To establish and identify DFM leader membership based on Departmental and Clinical section needs, within 12 months.
   • To identify leadership requisites of each clinical section in order to provide role clarity and better recognise emerging leaders within 12 months.
   • Explore the financial environment for clinical leaders, in order to ensure that compensation balances the time requirement and sufficient work life balance.
   • Develop a framework to encompass recognition of long service, awards and contributions to Family Medicine within the next 12 months.
   • Develop leadership training/orientation education including opportunities for compensation.

Recruitment/Workforce Plan

1) Create and accurate and appropriate workforce plan based on a clear understanding of the department/section landscape and how it influences recruitment.
   • Assess current workforce plan/framework for appropriateness to see how it addresses current strategic direction.
   • Consolidate workforce plan data and provide Actual Vs Estimated data to each clinical section, in order to more accurately forecast needs for the next Work Force Plan cycle within 12 months.
   • Develop recruitment strategies and reporting structure that better support the changing workforce planning landscape through enhanced interaction between clinical sections within the next 12 months.
   • Communicate departmental workforce plan with Academic leadership to better inform recruitment and planning needs within 12 months, and continue as an ongoing priority.
   • Provide update from Medical Affairs regarding provincial workforce planning including FTE definitions and information.
DFM Strategic Plan

Benefits of Belonging
1) To create a comprehensive package outlining the Department of Family Medicine Benefits of Belonging within a 12 month period, through extensive interaction between each of the six clinical sections.

Education/Training/Research
1) Collaborate with academic leadership to work with clinical sections to provide sufficient teaching support through workshops or other specific training within 12 months.
2) Enhance communication with academic leadership to ensure that program requirements are meeting the needs of the community, including capacity issues, expectations upon graduating etc. within 12 months.
3) Develop clinical service guidelines, including privileging and/or mandatory requirements, clinical procedures, which will allow each section to increase communication linkages with Academic DFM.
4) Gain a better understanding of the DFM role in CPD and CME through interaction with each clinical section and determine capacity for the department to increase growth in this area, within 12 months.
   • Acquire a better understanding of the CME process and disseminate information throughout the DFM.

Continuity of Care
1) In partnership with primary care and AHS partners conduct an environmental scan and gap analysis related to patient care plans, discharge planning and roles of the MDT team and specialists and disseminate the results.
2) Develop criteria and receive approval from Medical Affairs for “Supportive Care Privileges” that will allow family physicians to visit their patients in acute care facilities.

Evaluation
1) Develop a Departmental Quality Assurance framework inclusive of patient safety/adverse event reporting and patient concerns processes.
2) Engage clinical sections to develop a list of reportable events including adverse events, patient concerns, community or provincial tracking.
3) Develop a dashboard reporting system for each clinical section within 12 months to assist with program evaluation.
4) Engage Academic/clinical sections to better understand Quality Improvement landscape.
   • Initiate QI project(s) relevant to DFM medical home within 12 months’ time.
DFM Strategic Plan

3 – 5 Year Goals (2015-2018)

Support Systems
Clinical and Academic Appointment Processes
1) Provide privileging services to Family Medicine Physicians in order to meet the needs of family medicine within 30-45 days.

Recruitment/Workforce Plan
1) Accurately forecast the workforce planning needs based on section requirements, capacity constraints and academic opportunities.

Education/Training/Research
1) Resident and medical student training will be informed through enhanced communication linkages with each clinical section.
2) Create a robust forecasting process for CPD and CME requirements and implement section specific activities as informed through the 12 month plan.
3) Develop a recognition program for non-family physician educators who work within a team based environment with the Department of Family Medicine.

Continuity of Care
1) Assist in the development of tools and templates that will assist family physicians in care planning and discharge planning.
2) Engage AHS partners such as Information and Privacy to address flow of patient information to/from family physicians.

Evaluation
1) Enable accurate and relevant data to be available through DIMR for each clinical section, with reports generated quarterly.
2) Increase collaboration for transparent data/information sharing between family medicine partners including CPSA, College, and Primary care Networks etc. within 3-5 years.
3) Decrease the number of adverse events with strong reporting guidelines through taking an active role in Quality assurance and patient safety within next 3-5 years.
Clinical Family Medicine
The Maternal Newborn Care section (MNB) currently has 134 privileged physicians that offer low risk maternity care among ten Low Risk Maternity clinics within the Calgary Zone. These physicians work in a rotational ‘call group’ that provide 24/7 coverage at each of the four maternity care sites- Foothills Medical Centre, Peter Lougheed Centre, Rockyview General Hospital and South Health Campus.

The Calgary Zone offers a unique blend of maternity care providers that is not seen in other urban Alberta Zones. Maternal Newborn Care physicians, work in collaboration with a full spectrum of care providers including, Obstetricians, Midwives, Pediatrics, Anesthesia, Nursing, Public Health community services, Primary Care Networks and other stakeholders to provide quality maternity care.

This past year saw many successes within the Maternal Newborn Care section. One of the primary initiatives for this section was to enhance engagement with our physicians in a variety of different ways with an emphasis on quality activities. This section was able to harness the skills and passion of our residents to assist us with the many Quality Improvement activities for this past year. This was a positive relationship which will continue throughout 2015.

Other successes included electronic periodic review processes, increased communications and collaborations between departments and stakeholders as well as a very successful Pregnancy Parable event held January 2015. Alongside the above successes there were some substantial challenges that affect the Maternal Child landscape across the Calgary Zone.

The primary challenge was the Maternal Child Volume Redistribution discussions. Primary discussions occurred in early 2014, and were met with some reticence. Despite this, there was general agreement for a governance document to be formalised which addressed some of the volume concerns at the Foothills Hospital. The volume redistribution challenges continued throughout 2014, and in early March 2015, the group was reconvened. This meeting took a different direction to address these issues, and outcomes moved towards each site developing key strategies to assist with capacity issues. Family medicine physicians have been working on key strategies to ensure they align with what Senior Leadership has asked of the Zone. Further discussions will occur throughout 2015.

The DFM is able to extract data from Data Integration Measurement and Reporting (DIMR) in order to report on those admissions and deliveries that are specific to Family Medicine Low Risk Obstetric Physicians.

| From Dec 1, 2013 to Nov 30, 2014 there were 18471 deliveries in the Calgary Zone. |
| Calgary Zone family physicians were responsible for 46.66% of admissions to Labour & Delivery Units and 33.90% of Calgary hospital deliveries |
Maternal Newborn Care

Calgary Zone family physicians were responsible for:
  - 46.66% (8,618) of admissions to Labour and Delivery units
  - 33.90% (6,262) of Calgary hospital deliveries
  - Family Medicine delivers 72.66% of the patients that they admit

Calgary Zone - C-Section Deliveries
  - Calgary Zone had 5481 c-section deliveries for the period Dec 1, 2013- Nov 30, 2014
  - 29.6% of all deliveries were c-section delivery
  - Family Medicine admitted 21.20% of those c-section deliveries

Family Medicine - Unassisted Vaginal Delivery
  - Of the 9950 spontaneous vaginal deliveries in the Calgary Zone, Family Medicine was responsible for 56.13%

Family Medicine - Forceps/Vacuum Delivery
  - Of the 3040 deliveries involving Forceps/Vacuum in the Calgary Zone, Family Medicine admitted 22.04%

Family Medicine - Inductions
  - Of the 6386 Calgary Zone deliveries that included an induction, Family Medicine was responsible for 31.82%

Family Medicine – Postpartum Hemorrhages (PPH)
  - Of the 1379 reported PPH in the Calgary Zone, Family Medicine was responsible for 39.01%
ACCOMPLISHMENTS & HIGHLIGHTS

ACADEMIC ENGAGEMENT

In late 2014 a working group was set up with the Academic team to start discussions on resident and the skills required to meet needs of the section. Timing of the R3 program, Enhanced Skills program and evaluation process were also included in this discussion.

This was a very positive interaction, and as a preliminary step, a workshop was set up in March 2015 to assist our physicians with the evaluation process for residents.

Further work by this group includes collaborating to better align enhanced skills and Maternal Newborn privileging requirements.

BEDSIDE ULTRASOUND CERTIFICATION COURSE

In late fall 2014, family physicians at Riley Park Maternity Clinics engaged in an emergency ultrasound course. The purpose of the course was to allow Family Medicine Maternal Newborn Care physicians to use ultrasound to assess fetal position, amniotic fluid levels and placental location. Family medicine physicians are working collaboratively with the Department of Obstetrics at Foothills Hospital to assist with supervised scans following the course. The primary focus for utilising the US scans is to check that the babies are cephalic and not breech. This group will assess the benefits of using bedside ultrasound in the clinic and hope to progress technique to include amniotic fluid measurements.

Catherine Berezniki, FM resident, is currently conducting a QI initiative to look at missed breech presentations in labour at FMC, following the implementation of bedside US. DFM has been working with DIMR to help breakdown the data reporting for breech codes and assist in finding a meaningful way to understand comparisons directly. Findings are still to be reported.
COLLABORATIVE CARE PROJECT

This project extends to all maternity providers in the Calgary Zone and utilises the Obstetrical Consultation and Transfer of Responsibility standard of practice, as well as the Care of Women who are Appropriate for Vaginal Birth after Caesarean Section (VBAC) in Calgary protocol.

Early 2014, the Maternal Newborn Care section initiated a prospective VBAC audit that spanned across all four maternity care sites. This audit captured how effective the protocol is and whether appropriate consent is being given across the Zone. Results of this audit showed that there was a general agreement (52.7%) that the protocol is effective; however there was a significant absence of consent documentation evident. This prompted a further chart review. Kimberley Kiss, Family Medicine resident, is helping assess how effectively Trial of Labor collaborative information between Family Medicine, Obstetrics and Midwifery are being followed, as well as accessing how routinely AHS consent forms are being utilised and documented in patient charts. A random AHS chart audit was conducted. The results confirmed that there was a significant absence of Trial of Labour Information being given and documented as well as AHS consent forms. The outcome to this audit was to increase the education amongst all maternity providers, as well as to improve the ease to which Trial of Labour documents are accessed through the AHS internal website- inSite. As a priority the DFM Maternal Newborn Care Consultant created a document to educate providers on the process and worked with Web Communications to ensure that appropriate documents are now available online instead of previous practice of ordering paper copies through the Data Group.

Miss Kiss is currently narrowing her audit to the Northwest Maternity Clinic, and so far, positive outcomes for family medicine are evident within the clinic. This process may require further review.

COMMUNICATIONS

Communication Survey
A survey was distributed early 2014 to better understand the types of communication that is most easily received by physicians. The aim was to look to see how many physicians have an AHS email account, and identify where there may be a potential overlap in communications between the DFM and Primary Care Networks.
**MATERNAL NEWBORN CARE**

Results showed that many physicians have AHS accounts but do not use them. Our physicians also stated that they did find an overlap in communications; however the content is consistent between DFM and PCNs. Finally Maternal Newborn physicians tend to read emails that are sent from their Site Lead/Section Chief as a priority.

Other feedback was generated regarding site specific challenges and successes. This information demonstrated a further need to communicate with sites specifically.

In the summer 2014 a town hall meeting was held at the Rockyview General Hospital. The Zone Clinical Department Head, Maternal Newborn Care Section Chief and RGH Site Lead all chaired this meeting and gained valuable insight into culture and challenges. A follow up memo was distributed to RGH physicians with the outcomes clearly defined. Further engagement with physicians will need to occur in 2015.

**Midwifery Communications**

Some challenges were expressed regarding the transfer process between family medicine and midwifery, especially those clients who are late in their pregnancy. A collaborative discussion occurred, and a communication memo was distributed endorsing patient centered care and interaction between family medicine and midwifery.

**COMMUNITY INVOLVEMENT**

One of the Maternal Newborn Care physicians is doing a walk to support pregnant women in third world countries. CARE Canada’s I Am Powerful Council (IAP) Calgary has been tasked with raising funds for CARE Canada’s Tabora Adolescent and Safe Motherhood (TABASAM) project in the Tabora district of Tanzania, where there is an estimated 454 maternal deaths per 100,000 live births (UNICEF 2010). TABASAM is working to safeguard women’s health during pregnancy, childbirth and through the immediate postnatal period. Overall, this project is expected to impact 1.6 million people.

Specifically, for 2015 the IAP Calgary pledges to raise $231,000 to purchase 14 retrofitted vans for emergency transportation to TABASAM. These vehicles will be located at 14 selected health dispensaries within the Tabora region that satisfy the following criteria: remoteness, high maternal mortality, high birth rates, extreme poverty and distance from referral centres. The vehicles will be used to transport labouring women to safe delivery centres and those with obstetrical complications from basic health centres to hospitals for more appropriate treatment.

IAP Calgary launched CARE Canada’s Walk in Her Shoes campaign on March 8, 2015. Participants pledged to walk a similar distance to women in the developing world for one week, about 8000 steps per day. It was a resounding success! Over $35,000 in donations were collected for emergency transportation in Tanzania and the Government of Canada has matched this 13:1 through Foreign Affairs, Trade and Development Canada, making the positive impact on the lives of those in the Tabora region of Tanzania even more substantial.
CONTINUING MEDICAL EDUCATION

Pregnancy Parables

Pregnancy Parables is an annual event hosted by the Maternal Newborn section. It includes a ‘hot topic’ speaker as well as an opportunity for our physicians to collaborate and network with other family physicians, midwives, obstetricians, nurses and other professionals in the area of obstetrics. This event was held in January 2015 at Fort Calgary, and based on our evaluations, was very well received. The topic that was showcased during this event was ‘Tips and Tricks for the Perfect Repair’. Dr. Bruce Allen from the Department of Obstetrics and Gynecology spoke passionately to a group of 90 peers on obstetrical vaginal repairs. Dr. Allen has spoken at previous Pregnancy Parable events, and is highly regarded amongst our family physicians.

This event also affords us the unique opportunity to highlight and promote some of the many accomplishments of the Maternal Newborn Care section over the year. Two of our residents who assisted with the Maternal Blood Loss QI project this year also presented. This duo provided an educational demonstration with examples of blood loss, and a contest was held to see which physician could estimate blood loss most accurately. The residents then presented their research poster to the group.

This year we invited our community perinatal care partners to come and showcase some of their programs. This demonstrated a great partnership and will continue in the future.

Below is the breakdown of our audience for Pregnancy Parables this year. This event is attended by many different providers; however our main attendees remain to be Family Medicine physicians.
Current Obstetrical Management Seminar (COMS) CME Event
The University Of Calgary Cumming School Of Medicine is host to one of the only obstetrical management seminar programs in Alberta. This program is intended for family physicians, midwives and nurses working in urban and rural settings. It provides an opportunity to review and update knowledge and management of normal and abnormal obstetrical cases. Dr. Deb Hitchcock, who is the Maternal Newborn Care Site Lead at the Rockyview Hospital, chairs the planning committee for this event. It is a day long course, and was held on Oct 24, 2014 with approximately 300 attendees. This year’s program will be on Oct 23, 2015.

OTHER MATERNAL CARE ENGAGEMENT

Women’s Health Ambulatory Care
This year the Maternal Newborn section worked with the Women’s Health Ambulatory Care to provide feedback for development of a Miscarriage and Stillbirth Checklist, as part of the Pregnancy Loss and Referral Process. This process will assist physicians within the acute care setting.

There is ongoing work with the Women’s Health Resource Centre on the Care after Death initiative in the Calgary Zone.
Primary Care Team Collaboration
The liaison for Women’s health within the AHS Primary Care Team is a key stakeholder within the Maternal Newborn Care section. Regular meetings occur to communicate initiatives and better understand linkages with the Primary Care Networks within the Calgary Zone.

**PERIODIC REVIEW ELECTRONIC PROCESS**

This year the Maternal Newborn Care section piloted an electronic periodic review process using an AHS approved survey platform- Survey Select. A standardized process was created in collaboration with the DFM Physician Services team. Once this electronic survey process was launched in September 2014, three other DFM sections also participated (Seniors Care, Palliative Care and Community Primary Care). An electronic process has enabled enhanced communication with our physicians, and made the review process more user-friendly. Our survey results indicate increased satisfaction compared to a paper based process and has been very positive. There has been engagement across clinical departments to better understand our process and learnings. Further work to streamline this process and help the remaining two sections (Medical Inpatient and Urgent Care) to initiate this system will occur throughout the spring and summer 2015.

**PRIMARY CARE NETWORK COLLABORATIVE INITIATIVES**

Airdrie Women’s Health Clinic
The Airdrie Women’s Health Clinic was formed through the Highland PCN with Family Medicine involved in the planning process and helping understand the nature and needs in this clinical setting. This clinic opened in the fall 2014 and family physicians that work out of the Peter Lougheed Hospital have been communicating regularly.

Antenatal Colostrum Project
This pilot project has been initiated by the Calgary Foothills Primary Care Network- Riley Park Low Risk Maternity Clinic, and is in collaboration with Maternal Newborn Care section, Labor & Delivery Unit 51 and Post-partum Unit 52 at the Foothills Hospital.
The aim for this pilot is to facilitate exclusive breastfeeding in our mothers who have infants at risk for receiving formula supplementation in the early neonatal period. By encouraging antenatal expressing and storage of colostrum prior to admission to the Foothills Hospital Labor and Delivery Unit, family physicians hope to drastically reduce the amount of formula supplementation.

This project is in direct response to the recent revisions to the Calgary Zone Blood Glucose Monitoring and Feeding of the Infant at Risk for Hypoglycemia and L&D and Postpartum Practice Guideline which states that health providers are to ensure the first feed is initiated within 60 minutes of birth.

This project launched April 2015 and will continue with data collection until September 2015. If this pilot has positive results, it is anticipated that results will be presented to all the low risk clinics and maternity care sites, with the hope of adopting a similar process.

Frenotomy
The Maternal Newborn Care section has been an active participant with the Frenotomy Working Group. Current work includes:

- Revision of the frenotomy patient handout
- Work with health information to create a simple version with pictures
- Engage low risk clinics and Midwifery to participate in Frenotomy referral process
- Engage in cross provincial learnings to assist other health authorities in setting up this process

The Maternal Newborn Care section also hosted a Frenotomy workshop in the spring 2014. This event was presented by Dr. Mary Jo Woolgar and well attended.

Rhogam Referral and Distribution
Pregnant women who are Rh negative may require a Rhogam injection during the antepartum period. The process for obtaining Rhogam within the Calgary Zone is being reviewed due to several events during 2014 that led to some queries regarding Rhogam distribution and communication. The Maternal Newborn Care section in conjunction with the AHS Primary Care Team are working to convene a meeting to discuss and audit the process and make any revisions if required. It is anticipated that a formal Rhogam referral and distribution process will be communicated in 2015.
MATERNAL NEWBORN CARE

REPORTABLE/ADVERSE EVENT FRAMEWORK

The Maternal Newborn Care section has been working to create a sustainable process for reporting and reviewing events of significance in alignment with Quality and Patient Safety. The aim is to improve the communication among physicians when an adverse event occurs. The process includes a notification algorithm for physicians involved in an event and will be communicated broadly. The second stage helps our leadership team through the ongoing management of an adverse event. This process aims to launch May 2015 and the framework may help guide other DFM sections towards developing their own specific process.

CHALLENGES

Maternal Newborn Privileging Processes
The Maternal Newborn Care section has recognised a need to more clearly outline the privileging processes for Maternal Newborn Care locums. Work is being done with DFM Physician Services to ensure that locums are being privileged correctly. This work will continue throughout 2015.

Women’s Health Governance Document Process
The Zone Women’s Operational Committee (ZWOC) has been working with Clinical Policy to create a streamline process for revision or creation of Women’s Health governance documents. The Maternal Newborn Care section has been a key player in initiating this process after a substantial gap in the process was recognized. It is anticipated that this guideline will assist the ZWOC in undertaking critical revisions of documents. There have been five governance documents that have been identified for revision which will begin in the summer 2015.

Uninsured Patients Working Group
There has been a substantial issue identified regarding uninsured patients requesting prenatal care in the Calgary Zone or presenting at one of Calgary Zone Maternity Care sites in Labour and Delivery. A collaborative working group from family medicine, obstetrics, midwifery, anesthesia and paediatrics are currently working to develop a Zonal plan for addressing uninsured maternity patients.

Women’s Health Volume Redistribution
During the spring 2014, AHS Senior Leadership called a Maternal Child town hall meeting to discuss the issues regarding volumes at each of the maternity care units. Although this meeting created many questions, there was endorsement for a new governance document to transfer late preterm 32-36 week labouring mothers from FMC to another site, primarily Rockyview Hospital. Family Medicine has been working cohesively with obstetrics at the Foothills Hospital during 2014 to adhere to this guideline.
Early 2015, another meeting was called to further the Volume Redistribution discussion. The premise of this meeting was to make site based leadership teams have a plan for distribution of deliveries to optimize access, quality and safety in a sustainable way. Senior Leadership was hoping to gain consensus regarding targets set by each site. This was met with some questioning, resulting in the need to engage each site separately to work on some key volume specific strategies. This work will continue for 2015.

QUALITY ASSURANCE, QUALITY IMPROVEMENT & INNOVATION

MATERNAL BLOOD LOSS

This year the Maternal Newborn Care section underwent an intensive quality improvement project to understand and assess maternal blood loss, specifically blood loss resulting in a post-partum hemorrhage in the Calgary Zone.

In order to identify a postpartum hemorrhage, the practitioner must be able to quantify blood loss. There is no systematic way of measuring blood loss at this time. In order to optimally diagnose and therefore treat postpartum hemorrhage to prevent maternal morbidity and mortality providers’ accuracy of blood loss estimation is critical. This project will explore the accuracy of low risk obstetric providers at estimating blood loss during vaginal deliveries.

In the Calgary Zone, statistics provided by Data Integration Measurement and Reporting (DIMR) suggest that numbers of postpartum hemorrhages (PPH) have been trending high over the last year for Family Medicine Maternal Newborn Care physicians in the Calgary Zone. This project will be part of a larger project by the Maternal and Newborn Care Committee that would like to look at whether there is an issue with reporting (due to blood loss estimation) or is patient management a possible cause for an increase in PPH statistics.

This QI project had two components. First, a simple prospective audit was conducted, in which each physician was asked to estimate maternal blood loss post vaginal delivery. The physician then accurately weighed blood loss according to a pre-determined protocol.

The second component involved a more detailed chart audit to review the charts that were involved in the initial prospective audit stage.
Below is a table outlining the average patient characteristics:

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Age (years)</td>
<td>29.5</td>
</tr>
<tr>
<td>Maternal BMI</td>
<td>25.2</td>
</tr>
<tr>
<td>Gestational Age (weeks)</td>
<td>39.7</td>
</tr>
<tr>
<td>Birthweight (grams)</td>
<td>3355</td>
</tr>
<tr>
<td>Multiparous</td>
<td>19 out of 38 (50%)</td>
</tr>
<tr>
<td>Primiparous</td>
<td>19 out of 38 (50%)</td>
</tr>
<tr>
<td>Spontaneous Vaginal Delivery (%)</td>
<td>35 out of 38 (92%)</td>
</tr>
<tr>
<td>Vacuum delivery</td>
<td>3 out of 38 (8%)</td>
</tr>
<tr>
<td>Induction (%)</td>
<td>7 out of 38 (18%)</td>
</tr>
<tr>
<td>Charted as PPH (%)</td>
<td>13 out of 38 (34%)</td>
</tr>
</tbody>
</table>

The outcomes of this project showed that most practitioners underestimated blood loss.

- 35 of 38 cases were found to be an underestimation of blood loss
- Mean estimated blood loss was 371 mL (SD 154, Std error mean 25)
- Mean actual blood loss was 743 mL (SD 468, Std error mean 76)
- Mean difference EstMatBL – ActualBL = -372 mL (SD 406, Std error mean 66)
- On average, practitioners underestimated blood loss by 372 mL
- There was no significant correlation between maternal age or parity and blood loss

The graph below shows the differences between actual blood loss and estimated blood loss.
The data obtained from this project was helpful for our leadership team. It is evident, that an education intervention would be beneficial for our physicians despite some accuracy issues with the data. Learnings will be communicated in 2015. A second data collection cycle is required, with improvement in the gravimetric method, to improve the accuracy of the data collected.

**Future Directions & Initiatives**

The Maternal Newborn Care leadership team will be continuing to engage in quality initiatives as a key focus. The committee will meet mid-April to look at possible projects.

The section is also looking at how to enhance referral guidelines and the optimal route for communicating this information. The Alberta Referral Directory is a possible solution and the leadership team will engage with key stakeholders to assess its effectiveness.

Ongoing work will occur to ensure alignment with the Volume Redistribution working group.

This coming year will see some exciting capital works at the PLC. There are renovations in the works that will affect NICU/Labour & Delivery, Post-Partum and Triage. Family Medicine is working with the Capitol project team on design and decanting unit strategies. This venture will have an impact on Maternal Newborn distribution planning over the next few years, and will be an item of discussion in this planning process.

One of the Maternal Newborn physicians, Dr Allison Chapman, has started up another Centering pregnancy program out of the Alex. The Centering Pregnancy program, located in the Alex Family Health Centre, provides prenatal group care to new mothers and their families or support person. Groups are led by a physician and childbirth educator, or a nurse. Each session starts with an individual check-up with the physician and the rest of the session is spent in an interactive setting, doing activities, sharing stories and learning about pregnancy and prenatal care from each other and health care providers. This is a great way to make friends with others who will give birth the same month that you are expecting.

Literature has shown that group prenatal classes are associated with positive outcomes for mom and baby. We appreciate our family physicians initiating important services to our community, and will review successes of program in the upcoming year.

In conclusion, the upcoming year will be geared towards engagement and implementation of changes. There may be challenges along the way; however the leadership team will work cohesively to ensure minimal impact to patient centered care. Our primary goal is to support our physicians through this year of change.
Medical Inpatient Care

Accomplishments & Highlights

South Health Campus Rapid Access Unit (RAU) Evaluation

This innovative program serves as an integral component to a patient’s medical home, providing a scope of acute care services, working with the patient’s personal family physician. The RAU serves as a defined link between the patient’s medical home and hospital based services to ensure timely access to patients referred for investigations, treatments and consultations needed outside of the personal family physician’s practice.

As a 24 – 48 hour short stay unit geared towards a subset of hospitalist appropriate patients, the RAU is specifically staffed and equipped to receive medical patients presenting with acute non-critical medical illness from the emergency department (ED) or directly from a community family physician for expedited multidisciplinary team and medical assessment (including access to specialists), care and treatment for a short period of time (up to 48 hours) prior to transition home or transfer to an inpatient unit where appropriate. There is a focus on strong coordination and transition back into the community to support more effective patient health outcomes.

An evaluation was conducted to assess impact of this model of care related to length of stay and readmission rates when compared to a similar patient population admitted at the other three acute care sites (offsite admissions) without readily available access to this model of care.

RAU Assessment Criteria for Appropriate Patients

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18 years or greater</td>
<td>Pregnancy &gt; 20 weeks or a pregnancy related cause of admission</td>
</tr>
<tr>
<td>Hemodynamically stable</td>
<td>Patient requires stay &gt; 48 hours</td>
</tr>
<tr>
<td>Low risk of requiring ICU care</td>
<td>Likely requires placement to a new facility on discharge</td>
</tr>
<tr>
<td>Suitable for a Family Physician run service</td>
<td>Significant rehab required (&gt; 48 hours)</td>
</tr>
<tr>
<td>High likelihood of requiring a stay of &lt; 48 hours</td>
<td>Likely to require surgical intervention</td>
</tr>
<tr>
<td>The patient requires admission to hospital (cannot be easily managed as an outpatient)</td>
<td>Undiagnosed chest pain</td>
</tr>
<tr>
<td></td>
<td>Requires telemetry or BIPAP</td>
</tr>
<tr>
<td></td>
<td>Requires hemodialysis or peritoneal dialysis</td>
</tr>
<tr>
<td></td>
<td>Primary psychiatric presentation</td>
</tr>
</tbody>
</table>

Overall, the length of stay was significantly lower in the RAU admitted group compared to the offsite admissions group. A 36% reduction in length of stay was demonstrated, with the patients admitted to
MEDICAL INPATIENT CARE

RAU staying an average of 68.18 hours in comparison with 106.27 hours in the offsite admission group. This difference was statistically significant with a p-value of 0.016.

![Percentage of Patients Discharged Within 48 Hours](image)

**ALOS to ELOS ratio**

The Actual Length of stay (ALOS) compared to Estimated Length of Stay (ELOS) ratio reflects the relative amount of time that a patient stays in hospital when compared to an estimated length of stay created by the demographical and diagnostic information. As illustrated in Figure 3, the average ALOS/ELOS is 1.024 for the patients admitted at other hospital sites. This demonstrates that hospital stay for “offsite” patients align with the national norm captured by the Canadian Institute of Health Information. The
ALOS/ELOS ratio captured for RAU patients significantly lower, at 0.678. This is a statistically significant difference with a p value of 0.031.

**Actual to Estimated Length of Stay ratio (ALOS/ELOS)**

**Readmission Rates**

Readmission rates were captured and compared. Patients in both groups were tracked to identify any readmissions to hospital in the Calgary Zone within 7 and 30 days post-discharge.

In both study groups, there were no readmissions within 7 days after discharge. One patient from the offsite admissions group was readmitted to 16.5 days post discharge. There were no readmissions from the RAU group during the 30 day timeframe.

<table>
<thead>
<tr>
<th>Days post discharge</th>
<th>Ground ambulance use</th>
<th>ED visits post discharge</th>
<th>Inpatient Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Offsite</td>
<td>RAU</td>
<td>Offsite</td>
</tr>
<tr>
<td>0 – 7 days</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8 – 30 days</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
These results indicate that the Rapid Access Unit has been effective in reducing the overall length of stay in its target population. This review demonstrates that RAU is significantly reducing patient’s stay an average of 44 hours, discharging twice as many patients home within 48 hours and reducing overall length of stay by 36% without increasing readmission rates.

This model represents a novel and successful approach to enhancing patient flow. Further assessment is required to assess economic efficiency of this program.

**BEST SEDATIVE AND ANTIPSYCHOTIC FOR THE ELDERLY (B–SAFE)**

Patients admitted to hospital under the care of dedicated hospitalists often are taking multiple prescription medications on the background of a complex medical history. Many patients may not have a consistent, involved primary care provider in the community yet have seen several specialists each of whom may prescribe different medications without full awareness of the prescribing habits of other involved physicians. Some family physicians are understandably reluctant to make changes to prescriptions provided by consultants. This may lead to a “vicious circle” of poly-pharmacy.

Admission to hospital under the care of a hospitalist presents an opportunity for the attending physician to address multiple presenting issues some of which may be chronic and attributable to multiple medications with common and additive side effects.

The use of anti-psychotic, sedative and anxiolytic medications amongst seniors is prevalent without clear evidence based justification for efficacy and safety. The percentage rate of psychotropic use amongst seniors on public drug programs as reported by CIHI for 2009-2010 in Alberta was 22.4% for benzodiazepines and related drugs, 17.3% for antidepressants and 3.6% for antipsychotics (excluding nursing home patients). A recent study has demonstrated that ED visits and hospital admissions due to adverse drug reactions amongst seniors in Canada cost an estimated $35.7M with more than 80% of the costs arising from hospitalizations. Antipsychotic drugs were identified in the top 10 drug classes most commonly associated with senior’s adverse drug reaction related admissions. The American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (American Geriatrics Society April 2012–vol. 60, no. 4) gives strong recommendations that a number of these medications be avoided with a moderate to high quality of evidence. Several national specialty societies participating in the Choosing Wisely campaign in the USA and Canada have identified anti-psychotic and sedative medications as a target for re-evaluation. The risks associated with utilization of antipsychotics and sedatives are well documented in the literature and recognized within AHS. The Seniors Care Strategic Clinical Network has developed strategies under implementation within long term care sites to guide the appropriate use of antipsychotic medications.
The objective of the B-SAFE project was to evaluate the prevalence of anti-psychotic and sedative/anxiolytic medications prescribed to Calgary seniors before, during, and immediately after an admission to a Calgary acute care hospitalist service.

Detailed feedback is being provided to hospitalist physicians about the anti-psychotic, sedative and anxiolytic prescription profile of their patients before, during and immediately after an acute care admission to a Calgary hospitalist service.

These reports will allow physicians to:
- Better understand the use of anti-psychotic and sedative/anxiolytic medications in seniors before, during and after an acute care hospital admission.
- Reflect upon possible changes and consider participating in an educational and/or clinical intervention.
- Re-evaluate practice and prescribing changes after an educational and/or clinical intervention.

While this project is still in progress this attention to sedative use already generated discussion amongst physicians and practice change. For example, the Rockyview group reached consensus that the ward call physician would redirect care givers to utilize non-pharmacologic interventions or prescribe a “once only” dose of sedative as required when contacted after hours for sedative orders and defer decision for continuous therapy to the most responsible physician the next day.

In addition to educational interventions involving experts from geriatric medicine, nursing staff and families were engaged to identify and implement strategies to mitigate the use of these medications. After a fixed period of time, the data will be re-collected and analyzed for changes and evaluation of knowledge translation.
Supporting AHS Performance Measures and the Medical Home

The section continued with its focus on AHS performance measures related to acceptability, safety, accessibility, appropriateness, efficiency and effectiveness. At the same time, the section supported the principle of the Medical Home with a family physician as the MRP providing episodic care in the hospital and transferring care seamlessly back to the patient’s medical home. Hospitalists serve as a part of the patient’s medical home team, collaborating with the patient’s personal family physician to provide timely access to acute episodic care. Central to service delivery design is linkage with each patient’s medical home, ensuring linkage with the patient’s personal family physician in the provision and coordination of comprehensive care as the patient moves through the continuum of care.

The Hospitalist program supports the patient’s personal physician in the provision of comprehensive care by collaborating in the management of undifferentiated illness and complex medical presentations. Working to meet the AHS mandate of accessibility and efficiency, the Hospitalist service is an integral linkage with the Patient’s Medical home – ensuring patients receive timely investigations, treatments and other consultations.

Acceptability

Patient Satisfaction with Hospital Care

Overall, patients are very satisfied with the physician communication aspect of their hospital care. In 2014-2015, 76% of respondents rated their overall care on hospitalist focused unit as 8, 9 or 10, where zero is the lowest level of satisfaction and 10 is the best. Results are derived from discharged patient surveys. Data may be limited by sample size (N = 125), which may potentially skew results such that variances between quarters might be more attributable to sample size rather than physician behaviour.

Together, the Hospitalist Service and Sub-acute service attended patients for

238,525 days in 2014.

Hospitalists admitted 13229 patients

(excluding RAU admissions) between January 2014 and December 2014.
Safety

Transfer of Care Communication Update

Effective communication and information transfer is central to patient safety. The primary purpose of transfer of care communication from shift-to-shift is to promote continuity of care and patient safety. Handoffs between care professionals within hospitals at shift changes are a
MEDICAL INPATIENT CARE

The World Health Organization (2007) reports that in a ten year period, failure in communication at handovers was the most common root cause of sentinel events in the USA and in Australia communication issues accounted for 11 per cent of preventable adverse events leading to permanent disability.

The FMC Hospitalist group developed an EMR based patient handover tool to allow for a consistent and comprehensive patient handover for ward call doctors. In year one, the physicians have adopted the concept but it remains underutilized. Work is underway to refine the process to better align with the current SCM referral process to increase uptake of electronic handover processes.
Accessibility
The section remains a key strategy and a significant contributor for access to, and provision of, inpatient medical care for family medicine level patients. The section continues to show strong performance in volume of service delivery and patient flow as demonstrated by “consult to decision admit” metrics.

Hospitalists admitted 13229 patients (excluding RAU admissions) between January 2014 and December 2014. The number of admissions is almost identical to the 2013 (13179 excluding RAU). This accounted for 94% of admissions by Family Medicine and 62% of total medical inpatient admissions (including admissions by Family Medicine and General Internal Medicine).

The Hospitalist Service attended patients for 168,298 days between January 2014 and December 2014, which represents stable volumes relative to 2013. The Sub-acute Service attended 94,359 days, a 24.0% increase from previous year, reflecting system wide challenges related to patient flow as patients receiving care under the Sub-acute service no longer require active medical intervention and could receive care outside of an acute care facility if an alternative was available.
### Medical Inpatient Care

#### Average Patient Census – Acute and Sub-acute Care

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FMC</td>
<td>235</td>
<td>236</td>
<td>253</td>
</tr>
<tr>
<td>PLC</td>
<td>177</td>
<td>162</td>
<td>176</td>
</tr>
<tr>
<td>RGH</td>
<td>241</td>
<td>228</td>
<td>254</td>
</tr>
<tr>
<td>SHC</td>
<td></td>
<td>71</td>
<td>92</td>
</tr>
<tr>
<td>Total</td>
<td>653</td>
<td>696</td>
<td>775</td>
</tr>
</tbody>
</table>

The Hospitalist program continues to be a major contributor to improving patient flow through the Emergency Department reflected by continued efforts to reach the target of 80% of consults with disposition within two hours.

The graphs below represent continuous improvement by all four acute care sites in reaching AHS targets and supporting safe and efficient patient flow.

#### Hospitalist Median Time (Minutes) From Consult Requested to Decision to Admit in ED

Average median time in 2014 was 104 minutes, a slight increase from 97.7 minutes in 2013 but remaining well below the target of 120 minutes.

#### Appropriateness

### Patient Demographics – Patient Age

#### Average Age (yrs) - Acute Care Hospitalist Service

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>73.3</td>
<td>73.4</td>
<td>73.9</td>
</tr>
<tr>
<td>PLC</td>
<td>69.9</td>
<td>68.8</td>
<td>69.1</td>
</tr>
<tr>
<td>RGH</td>
<td>74.6</td>
<td>75.8</td>
<td>76.5</td>
</tr>
<tr>
<td>SHC</td>
<td>74.3</td>
<td>77.6</td>
<td></td>
</tr>
<tr>
<td>SHC RAU</td>
<td>59.5</td>
<td>59.1</td>
<td></td>
</tr>
</tbody>
</table>
Top 10 CMGs

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>Heart Failure without Coronary Angiogram</td>
<td>Heart Failure without Coronary Angiogram</td>
<td>Heart Failure without Coronary Angiogram</td>
<td>Heart Failure without Coronary Angiogram</td>
</tr>
<tr>
<td>Viral/Unspecified Pneumonia</td>
<td>Lower Urinary Tract Infection</td>
<td>Viral/Unspecified Pneumonia</td>
<td>Lower Urinary Tract Infection</td>
</tr>
<tr>
<td>Lower Urinary Tract Infection</td>
<td>Viral/Unspecified Pneumonia</td>
<td>Lower Urinary Tract Infection</td>
<td>Lower Urinary Tract Infection</td>
</tr>
<tr>
<td>Organic Mental Disorder</td>
<td>Organic Mental Disorder</td>
<td>Organic Mental Disorder</td>
<td>Organic Mental Disorder</td>
</tr>
<tr>
<td>Dementia</td>
<td>Dementia</td>
<td>Dementia</td>
<td>Dementia</td>
</tr>
<tr>
<td>Non-severe Enteritis</td>
<td>Non-severe Enteritis</td>
<td>General Symptom/Sign</td>
<td>General Symptom/Sign</td>
</tr>
<tr>
<td>General Symptom/Sign</td>
<td>Psychoactive Substance Use, Withdrawal State</td>
<td>Non-severe Enteritis</td>
<td>Non-severe Enteritis</td>
</tr>
<tr>
<td>Disorder of Pancreas except Malignancy</td>
<td>General Symptom/Sign</td>
<td>Disorder of Pancreas except Malignancy</td>
<td>Disorder of Pancreas except Malignancy</td>
</tr>
<tr>
<td>Psychoactive Substance Use, Withdrawal State</td>
<td>Disorder of Pancreas except Malignancy</td>
<td>Cellulitis</td>
<td>Cellulitis</td>
</tr>
</tbody>
</table>

Efficiency/Effectiveness

ALOS/ELOS Ratio and Readmission Rates

The section continues to track LOS and readmission data on a site and individual physician basis to identify, recommend and/or implement system and individual strategies for improvement. The chart below reflects stable ALOS/ELOS ratios with a slight decrease in 7 day readmissions and a slight increase in 30 day readmissions.
### Patient Complexity

<table>
<thead>
<tr>
<th>Site</th>
<th>Resource Intensity Weight</th>
<th>Resource Intensity Level (2 to 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>FMC</td>
<td>2.9</td>
<td>2.9</td>
</tr>
<tr>
<td>PLC</td>
<td>3.1</td>
<td>2.6</td>
</tr>
<tr>
<td>RGH</td>
<td>2.3</td>
<td>2.2</td>
</tr>
<tr>
<td>SHC</td>
<td>2.1</td>
<td>2.4</td>
</tr>
<tr>
<td>SHC RAU</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>Total</td>
<td>2.69</td>
<td>2.34</td>
</tr>
</tbody>
</table>

### ALOS/ELOS vs RE-ADMISSION RATES

January 2012 to December 2014

- Acute LOS / ELOS
- Re-admission Rate (7 day)
- Re-admission Rate (30 day)
- Linear (Acute LOS / ELOS)
- Linear (Re-admission Rate (7 day))
- Linear (Re-admission Rate (30 day))
MEDICAL INPATIENT CARE

RIW reflects the relative resources (total hospital service cost including fixed and variable components), intensity (the amount of service utilized), and weight of each inpatient case compared to the typical average case, which has a value of 1.0000.

The RIL is a way of further distinguishing patients with higher resource use by partitioning the resource intensity factor into mutually exclusive levels. The base RIW values are assigned at the CMG and Age Category levels so the RIL variable only accounts for resource changes associated with the remaining four factors: Comorbidity Level, Flagged Intervention, Intervention Event, and Out-of-Hospital Intervention.

Rapid Access Unit

The Rapid Access Unit is an innovative service unique to South Health Campus to maximize system efficiency and effectiveness along with being an integral component of the medical home.

In order to address critical capacity pressures at SHC, a “Flex Service” was created, utilizing beds in the RAU to provide a temporary relief valve to enhance ED patient flow. The Flex Service was designed as a process to be invoked only when specific parameters are in place. The utilization of flex beds remains low relative to RAU admissions, demonstrating an innovative solution to meet the competing priorities of ED patient flow and maintaining capacity to meet the RAU mandate.
MEDICAL INPATIENT CARE

RAU Length of Stay

2013

2014

<48 hours
48-72 hours
>72 hours

RAU ALOS/ELOS Ratios

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

2013 2014
The majority of patients admitted to RAU are admitted to an inpatient unit or discharged home in less than 72 hours. ALOS/ELOS ratios consistently remain under 0.8 with very low readmission rates, representing efficient and safe patient flow.

**Sustainability**

**Leadership Development – Deputy Site Leads**

As highlighted in “AHS Dyad Leadership Model: A Primer” integration of clinicians into leadership is a key characteristic of high performing health care organizations. There is a need to build capacity within the medical staff community which includes support and training for clinical leaders. Clinical leaders are well placed to ensure quality and safety, coordinate care across the organization and foster relationships with fellow clinicians. Clinical leadership will be integral to the achievement of the strategic directions outlined in the AHS 2014-2017 Health and Business Plan.

Strong leadership is critical to the section. Recognizing this need, the section, in partnership with the Calgary Hospitalist Governance Association, has developed a strategy to identify and develop leaders
MEDICAL INPATIENT CARE

from its membership to ensure its continued success. Part of this strategy is to provide an annual PMI based program with content specific to the Section, CHGA and local needs which is subsidized by the CHGA to a cohort of leaders/prospective leaders with the expectation that participants actively engage in a leadership role in the next 12 month period. Since the inception of this strategy in 2012, 44 different participating physicians have attended one or more sessions with over 85% contributing in a leadership role over the course of the last three years. In the last year, the Section has created four Deputy Site Leadership positions and all positions have been filled by PMI program participants. This places the section in a strong position for succession planning and continuous strong physician leadership and engagement.

Recruitment
The section continues to actively recruit not only for program sustainability but also for growth as population demands increase. During the 2014-2015 year, the Section targeted three events for recruitment.

- Department of Family Medicine Showcase
- Residency recruitment and information night
- Canadian Society of Hospitalist Medicine Conference

Year after year, the Residency recruitment night has provided the most return to the program. Nine residents from the event held in the spring of 2015 have committed to work within the section in the next six months.

Teaching (Residency Program and Medical Students)
In the past year, the section has established the Resident Teaching Team Committee with representation from each Hospitalist program, the section and the Academic DFM. This forum allows the section to discuss and create strategies to optimize the learner’s experience and to support the preceptors as it is well recognized that the Residency program is a major source of new recruits. In addition, partnerships are being established to link family medicine residents to quality improvement projects within the section early the residency program to maximize opportunities for both the resident and the section. In 2014-2015, the section provided learning for 78 residents and 23 clinical clerks across the four sites.

CHALLENGES

Capacity/Patient Flow
The gap between population need for facility based community care and physical availability of appropriate spaces continues to be a challenge for the section. On a daily basis, patients awaiting placement account for up to 1/3 of total patient census. The “difficult to discharge” sub population has
a significant impact on patient flow and capacity with patients remaining on the sub-acute service for periods of months up to two or three years. To illustrate the challenge in patient flow, one site conducted a chart review and documented a snapshot of the discharge status of their entire census.

<table>
<thead>
<tr>
<th>Barriers to Discharge</th>
<th>Number of Patients</th>
<th>TOTAL LOS (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>As of October 7, 2014</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Issues of Capacity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Waiting RCAT Assessment</td>
<td>4</td>
<td>149</td>
</tr>
<tr>
<td>ii. Waiting Psychiatric Capacity Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. Waiting OT Cognitive Assessments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Transition Services (T.S)</td>
<td>9</td>
<td>103</td>
</tr>
<tr>
<td>i. Awaiting Assessment for Placement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Unable to Reach Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. Family Meeting Needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Facility Barrier - refusal to take patient back</td>
<td>14</td>
<td>467</td>
</tr>
<tr>
<td>i. Care Needs Have Become Too High</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Needs to Improve Mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. Behavioural issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Needs Rehab to Return Home</td>
<td>12</td>
<td>313</td>
</tr>
<tr>
<td>i. RCTP/ERCTP/GARP/MSK Waitlist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. PT working in hospital Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Psychosocial Issues - Difficult to Place</td>
<td>7</td>
<td>1328</td>
</tr>
<tr>
<td>i. Patient Smokes/Drinks/Behaviours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. Financial Concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Awaiting Consults from Other Services</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>i. OT Functional Assessments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Social Work (PD, POAs, Guardianship etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. On Waitlist for ALC</td>
<td>23</td>
<td>1310</td>
</tr>
<tr>
<td>H. Awaiting family decision re: hospice</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>I. Not Medically Stable (acute hospital stay medically necessary)</td>
<td>14</td>
<td>88</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>87</td>
<td>3789</td>
</tr>
</tbody>
</table>

Systemic issues creating barriers to discharge create challenges to the section when balancing requests to admit or transfer care of appropriate patients to the Service.
The Calgary Hospitalist Innovation Committee (CHIC) continued its mandate to identify, develop and implement quality improvement initiatives in alignment with the vision, mission and values of the Calgary Hospitalist Program, demonstrating an unwavering commitment to continuous quality improvement.

MD/RN Communication

A critical component of medical care is the communication between healthcare professionals in various capacities. It is recognized that the majority of errors reported in healthcare situations have a component of miscommunication involved. Part of this initiative is to minimize error, improve patient care and improve efficiency of communication. Efficient and informative transfers of information are needed to ensure that all patients receive the best care. Founded on frustration borne by both physicians and nurses, discussion about communication improvement began. In order to tackle this complicated and multi-faceted task, a well-designed survey was administered to validate the concerns that had been raised and focus on areas that could be targeted for improvement.

The MD/RN communication project that originated at the PLC was expanded to the other three sites. In total, 481 RNs and close to 90 SHC hospitalists from all four sites responded to the survey. The survey was utilized to focus quality improvement endeavours in the areas perceived as deficient and to identify units with favourable practices to examine their communication strategies.

Differences in expectations between the two groups related to:

- Level of preparation prior to paging physician
- Requirement for response to “FYI” page
- Availability/timing to respond to pages and follow up phone call
- Degree of urgency of clinical situation
- Communication and follow up of non-urgent issues

As a result a number of tools and interventions have been developed and implemented to narrow the gap between expectations, develop a common set of principles for communication and to improve effectiveness and patient safety.
Mosaic Primary Care Network Discharge Summary Review

The timely availability of discharge summaries is critical to continuity of care as patients transition from hospital care back to the care of the family physician in the community. The Peter Lougheed Hospitalist Program is achieving essentially 100% of discharge summaries completed at the very time of discharge. In addition to the timely provision of discharge summaries, the quality, layout and content must meet the needs of the community physician to achieve the desired impact of information transfer at transitions of care. Recent attention to medication reconciliation on discharge created an impetus to explore the elements of good medication reconciliation from the perspective of view of the receiving physician.

Participating community physicians each reviewed two to four discharge summaries with specific attention to the medication information and provided feedback and recommendations.

Overall, the community physicians were very appreciative of the discharge summaries received. They felt the summaries demonstrated great work by hospitalists for their patients in hospital and towards smooth transitions. Despite that, 54 perceived medication errors were identified through these detailed interviews referencing 23 specific discharge summaries. Most of these errors were medication omissions with fewer in dose and frequency. Only 55% of the community physicians were confident that they knew which home medications were changed in hospital.
From the point of view of the community physician, the solution was clear: the discharging physician should clearly list what they think the home medication list is. "My patient is on multiple meds not listed. I don't know if he is still on them, if they were stopped by the hospitalists or if he chose to stop them and they (the patient) didn't know." Illustrating the difficult and unsafe situation the community physician finds themselves in, one commented, "In this case, I revert back to what she was taking before, unless it relates to the reason for admission. I try to get information from the patient themselves and then make a decision on a middle ground." ALL doctors found that if there were no home meds listed, the overall use of the discharge summary was reduced.

The second recommendation from the community physicians is to explain every change. One stated, "There is no rationale for why this medication was discontinued. For us in the community, we wonder did they knowingly take the patient off the medication. Was it a mistake? You're always left with the uncertainty."

Finally, we were offered a community doctor perspective about the potential opportunities created by a patient’s episode in hospital.

"I interpret my patients’ stay in hospital as
a) A break or disruption in the care plan we both were working on, and
b) An opportunity for my patient to access scores of resources (investigations, imaging, specialist consults) they can’t get in the community.

If the opinions of these consultants could be concisely included in the D/S, the power of those visits could extend far beyond the stay in hospital and influence care in the community. The discharge summary is an opportunity to extend the reach of these resources by informing my care...if the decisions are explained."

Some of the consultants in hospital dictate their consults, in which case the community family physician has access to them in Netcare. More frequently, though, the consults are handwritten. For those, the community physicians would find a succinct summary valuable.
The recommendations are simple:

1) include the home medication list, and
2) explain every change.

These recommendations will be incorporated into medication reconciliation at discharge initiatives as the program moves forward. In addition to the valuable feedback received from colleagues in the community, this initiative demonstrates the important linkage our Hospitalists provide as part of the patient’s medical home.

**Hospitalist Nurse Liaison**

An important contributor to high quality patient care and efficient patient flow is the proactive identification and resolution of factors which may delay discharge or increase the potential for readmission early on during a patient encounter. The Hospitalist Nurse Liaison role has been in place for many years. With increasing patient census at all sites and the evolution of many system wide initiatives related to patient flow, the section undertook a review of the utilization of our nurses and how to best maximize the impact for our patients and the program.

As a result of the review, processes have been put into place for the physician and other allied healthcare providers to identify patients early in their encounter who would benefit from this resource as they move towards discharge.

Although other issues are not precluded, the primary focus of the Hospitalist Nurse Liaison is to assist with:

**A. Transitions of care**

1) arrange a family physician
2) no discharge location
3) multi-faceted discharge/coordinating services (i.e. mobile lab)
4) Predetermined discharge date requiring planning assistance
5) follow up appointments

**B. Multiple readmissions**

1) education and reinforcement of information
2) identify supports in community/maintain awareness of community programs to assist with maintenance of chronic complex disease
3) identifying contributing factors and mitigate (BOOST/8P)

**C. Advance Care Planning**

1) working through the “conversations matter” workbook
2) ACP tracking sheet
3) communication with care centres and family doctors re: ACP via the tracking sheet

**D. Family Dynamics**

1) family meeting coordination
2) ensure social work involvement
3) identify primary family contact
4) remain focused on resolving issues related to cause of admission/discharge barriers and assist with efficiency in these matters

The section recently unveiled an SCM based process for physicians and others to refer to the Hospitalist Nurse Liaison.
Key initiatives in the coming year include:

- Geographic rounding
- Antimicrobial stewardship
- Physician leadership development
- Electronic periodic review process
- HNL evaluation
- Hospitalist physician engagement
- Academic linkages
- Electronic ward handover process
- Foot Care (South Health Campus)
- Ongoing recruitment and refinement of the privileging process
- Support the Department in projects to improve patient flow and transitions of care
ACCOMPLISHMENTS & HIGHLIGHTS

The three rural and two urban urgent care centres within the Calgary Zone saw 182,692 patients in 2014. The urgent care health care team consists of highly skilled RNs, LPNs, Ortho Technologists, Mental Health Nurses, Unit/Registration Clerks and, in some centres, Nurse Practitioners. Urgent Care physicians typically are family practitioners with a special interest in acute care that may have completed an additional year of Emergency Medicine. Urgent care centres strive to fill any potential gaps between ambulatory community care and tertiary emergency care.

2014-2015 has been a very busy year within the urgent care centre environment. Our volumes specifically Sheldon Chumir have had a marked increase since 2013, averaging approximately 156 patients per day. Also, the acuity (the percentage of CTAS 123 patients to total volume) has also increased throughout all sites. Our LWBS have stabilized and at two sites Airdrie Urgent Care Centre (AUCC) and Sheldon Chumir Urgent Care have begun to decrease. Despite the aforementioned, we continue to provide exemplary episodic care to the clients we serve.

URGENT CARE REVIEW IMPLEMENTATION

We have been success in the implementation of approximately 95% of the Urgent Care Review report which was released in January 2014. Accomplishments to date include:

- Reviewed the physical space and submitted a Business Need (BN) for consideration of expansion of two existing meeting rooms
- Engaged QI and Clinical engagement and commenced work to identify flow and process improvement opportunities in AUCC
- Stabilized the Nurse Practitioner (NP) workforce. Completed literature reviews pertaining to NP roles within ER/UC and created focus groups to identify role clarification, scope of practice and accountability
- Reviewed and provided documents to reflect optimization of urgent care services to the communities they serve
- Developed competencies for physicians practicing within UCC's
- Provided monthly data for all UCC's reflecting the following indicators; volume, acuity, LWBS and transfer information
- Enhanced our provincial work, updating the UCC website with the most current practice guideline information and reviewing the provincial EMS transport criteria

Total number of patients seen in all 5 urgent care centres within the Calgary Zone (2014)

182,692
Sheldon M. Chumir Urgent Care
Chumir UCC Patients LWBS by CTAS 2014

Chumir UCC Patients LWBS by Percentage 2014
South Calgary Health Centre Urgent Care

**SCHC UCC Total Patient Presentations 2014**

**SCHC UCC Total Patient Presentations by CTAS 2014**

01-Resuscitation  | 02-Emergent  | 03-Urgent  | 04-Semi-Urgent  | 05-Non-Urgent
Continuing Medical Education

Urgent Care Rounds
Rounds are offered five times a year and have become so popular that we now have to look at limiting attendance to space available.

e-simulation
The e-sim group worked with each urgent care to coordinate one to two sessions per year.
Sedation Modules
The AHS mandated sedation online learning modules are to be completed every one to two years (depending on role) for UC staff involved in sedation.

CHALLENGES

Continuing Medical Education
The Urgent Care Conference of October 17, 2014, was successful with many participants. A decision to pause the UCC Conference for 2015 has been made due to increasing event costs.

FUTURE DIRECTIONS

Continued work on the implementation of the Urgent Care Review report recommendations is ongoing.
Palliative Care

Accomplishments & Highlights

Palliative Consult Teams

The palliative consult team performs the vast majority of expert level palliative care in the Calgary Zone. It currently consists of 25 physicians, one nurse practitioner, 13 clinical nurse specialists and five nurse clinicians. The consult teams function in a wide variety of health care settings including all four adult hospitals (Foothills Medical Centre, Peter Lougheed Centre, Rockyview General Hospital, and South Health Campus), Tom Baker Cancer Centre, home care (palliative, integrated), hospices, long term care, and all rural sites. The number of patients seeing our teams continues to grow each year at all of these sites. In addition to clinical provision, they also build palliative care capacity through education and support for primary teams.

Grief Support Program

The Grief Support program offers individual and group grief counselling to adults 18 years of age and older that has faced the death of a loved one. Clients access the program through self-referral and the program serves all types of death related loss. The average length of individual sessions is between five-to-eight sessions. All clients must see a counsellor to determine suitability for group counselling sessions.

During the time period of January 1 2014- March 15 2015, 1,376 unique clients attended services resulting in 6,491 individual and group patient encounters. There were approximately 1,280 new clients. The average wait time for clients attending their first appointment was 28 days.

During this time period approximately 570 clients attended the 31 groups provided during this time period. The types of groups offered were: Mature Spousal (11), Mixed Loss (12), Young Spousal (5), Loss of Child (5), and Sibling Loss (3).

The program also recruits trains and mentors volunteers. Currently there are 58 active volunteers in the program with a newly developed dedicated volunteer coordination role. The core function of the volunteers is to assist with group facilitation and most of the volunteers have come through the program themselves. The facilitation team for groups consists of lead facilitators who are a program clinician and two-to-three trained volunteers. In 2014 the program developed new training manuals for
volunteers & lead facilitators. The program also developed participant manuals that are now provided to all group clients.

In April 2014 the program introduced a new monthly single session group to support clients who are waiting for counselling. All new clients are invited to attend and bring support people if desired. Grief information is provided and volunteers share their grief journey as a means of support to new clients. Each session has two program staff and four volunteers. During the months of November-December four single sessions were offered specifically on Managing the Holiday Season. A total of 14 single sessions have been offered with approximately 235 clients who have attended and approximately 70 support people. Evaluations of these sessions have been very positive and have demonstrated a unique way to support those who are on the waitlist.

Starting April 2014 the program began collecting additional statistics to be able to report on the types of losses, the complexity of needs, and the cause of death of the individuals who have died.

The program continues to receive grant funding to support 2013 flood impacted communities. A counsellor (.8 FTE) has participated on multiple flood response initiatives and provided grief and trauma single session groups to those who have been impacted and multiple AHS and non AHS care providers.

During 2014 the program participated in the newly developed Calgary Homicide collaborative which has evolved from the need for services in Calgary to collaborate in response to the increase in the number of homicides. This collaborative included AHS mental health services, Calgary Victims’ Assistance and numerous community counselling services.

The Grief Support Program also offers grief and bereavement education to the public community and AHS. “The How to Care What to Say” workshop is a standard education program provided to AHS and contracted services that care for those who die and their families. From January 1 2014 - March 31 2015, 17 workshops were offered to a total of 570 participants. The program has also been heavily involved in developing educational materials for the AHS Calgary Care after Death project.
ADVANCE CARE PLANNING, GOALS OF CARE DESIGNATION

On April 1st 2014 a new Level 1 AHS policy and procedure for Advance Care Planning and Goals of Care Designation (ACP GCD) was implemented across Alberta. The Calgary Zone, ACP GCD team (Bev Berg, Manager, Dr. Jessica Simon, physician consultant, an educator, QA resource and administrative support) contributed to the provincial policy and procedure development and prepared “toolkits” for physicians, managers and educators to assist with the transition to the new policy. These toolkits have been nominated for an AHS President’s Excellence Award.

Over the course of 2014-15 the team has continued to enhance integration of the policy and procedure into practice. Acting on a strategic plan, informed by quality-gaps identified by a chart and discharged patient-telephone audit of ACP and GCD, this has included:

- Making the ACP tracking record document available on SCM the acute care electronic health record (Dec 2014)
- Updating the GCD order on SCM (Feb 2014 and Dec 2014) to align with the provincial form and enhance ordering clinicians’ documentation of who has been involved in the GCD determination.
- Focusing on education and engagement with ACP GCD practice in primary care networks (PCN)
As part of the latter, Bev Berg presented to the South Calgary PCN Physician Education forum in September 2014. Dr. Jessica Simon and Jacqui Pinto have provided on-demand Lunch and Learn sessions to individual practices in the Calgary Foothills Primary Care Network (about 10 provided since Oct 2014). In addition, through the University of Calgary, Continuing Medical Education for Primary Care Physicians Dr. Simon has presented an evening course, webinar and workshop at the 39th Annual Family Practice Review - Pearls for Practice all on ACP GCD. Additionally, all Family Medicine residents continue to receive a lecture of ACP GCD during the R1 orientation and a communication skills workshop on GCD conversations during their palliative medicine rotation.

In addition to local and provincial work the ACP GCD team remain active nationally. Both Bev Berg and Dr. Simon are members of the National Task Group for ACP. Through her work as a board member of Canadian Society of Palliative Care Physicians, Dr. Simon co-authored the Choosing Wisely Canada recommendations for Palliative Care, which included “Don’t delay advance care planning conversations.”

The team continues to participate in the provincial ACP GCD implementation committee and participated in the one year review of the provincial policy. The team also participated in a number of public forums reaching over 500 seniors at varying fairs.

**Intensive Palliative Care Unit**

The Intensive Palliative Care Unit (IPCU) at Foothills Medical Centre provides tertiary level palliative care for patients with complex palliative issues requiring acute care management in a comprehensive interdisciplinary setting. Our team is comprised of physicians, nurses, clinical pharmacists, occupational and physical therapists, dietician, spiritual care, recreation therapy, volunteers, and transition coordinators. Our goal is to optimize symptom management so that patients can be discharged to appropriate setting for ongoing care, typically home or hospice.

Palliative Medicine is a rapidly evolving area of medicine with both a growing patient population and an increasing body of research to direct clinical care. **In order to meet this need, the IPCU had increased from 21 to 29-31 beds in late 2013. For the 2013-14 fiscal year 618 patients were admitted to the unit.** The average patient age on IPCU is less than 60 (ranging from 18 years of age to well over 90) and average length of stay is less than two weeks. Most patients admitted are from the Calgary Zone, but the catchment area for referrals extends to other parts of southern Alberta and British Columbia.
The majority of IPCU patients are admitted directly from the community through contact with the Palliative Consult teams supporting the Palliative Home Care Service and the Tom Baker Cancer Centre. This allows for timely access to the system and minimization of Emergency Department visits for our patients and their families.

With the increased number of beds and clinical service workload, we have needed to switch from a two physician service to a three physician service model and we have been working to recruit additional palliative physicians for IPCU. In 2014, we mostly functioned with two physicians, but with new recruitment for 2015, we will be able to staff the unit with three physicians most of the time. This will also allow us more focus and capacity for our important academic domains of education and research in palliative care.

In 2014, Dr. Leonie Herx became the new Medical Director of IPCU, replacing Dr. Lyle Galloway who has been the Director for the past ten years. Dr. Galloway continues to work as a core member of the IPCU physician team and is leading the program development of the new Palliative Consult team within the Tom Baker Cancer Centre. This new outpatient program is an important referral source for IPCU.

IPCU is a principal site for postgraduate residency education, including Palliative Medicine residents who do four blocks of core rotations on IPCU, specialty residents including Medical Oncology, Radiation Oncology, General Internal Medicine, Anesthesia, Psychiatry, Critical Care, Neurology, and Physical Medicine and Rehabilitation, and Family Medicine residents. We also support a number of undergraduate trainees who are looking for a clinical experience in palliative care, typically during their clinical clerkship program. Medical students come from the University of Calgary Cumming School of Medicine as well as other program in Canada.

The Family Medicine residents complete a mandatory four week block rotation in palliative care during their first year. Two weeks of this block are typically spent on IPCU, during which time the residents will experience an interesting and challenging blend of: full-spectrum acute care palliative medicine with a patient and family-centered focus; immersion in a practice environment characterized by its sensitivity to patients’ community context and integration with community family physicians and the comprehensive community-based Palliative & End of Life Care service in Calgary Zone; interdisciplinary teamwork; regular collaboration with a wide variety of specialist physicians including psychiatry, anesthesia, medical and radiation oncology, interventional radiology, interventional pulmonary medicine, and surgical disciplines; and regular reference to evidence-based practice guidelines and medical literature. IPCU Journal Club rounds are held twice weekly and each resident is expected to present a recent article focusing on a palliative issue relevant to a patient they are following or question regarding palliative care.
**PALLIATIVE CARE**

**HOSPICES**

There are seven hospices in Calgary, with a total of 108 beds currently. This is expected to increase to 114 beds in 2015, with the closure of Santuari hospice and the opening of St Dulcina hospice. The other hospices include Agape, Chinook, Foothills Country, Rosedale, Santuari and Southwood. As a large program with many contracted providers, it is a priority to ensure a culture of collaboration and shared learning exists among our various contracted hospice providers. In an effort to operationalize this goal, there are a number of committees in place to provide forums for information sharing, collaborative education and project work, and resource sharing. These include the Hospice Executive Steering Committee, Hospice Quality Management Committee, Hospice Medical Directors Meeting, Hospice Clinical Nurse Educators Committee, Hospice Social Workers Meetings and Hospice Volunteer Coordinators Meetings.

Foothills Country hospice in Okotoks recently passed their accreditation with commendation that is a credit to all the staff there. They also have many community partners that work hard to keep their doors open.

**ACADEMIC PALLIATIVE MEDICINE**

The University of Calgary Palliative Medicine Residency Program provides advanced training for physicians wishing to develop added competence in Palliative Medicine. The University of Calgary Palliative Medicine Residency Program currently has two enrolled trainees in the 2014-2015 academic year, one from the Department of Family Medicine and one from the Department of Critical Care Medicine. Residents are trained in the both the hospital and community palliative care team environments, including the Palliative Home Care Service, the Intensive Palliative Care Unit, the Inpatient Hospital Consult Services, Pediatric Palliative Services and Calgary Hospices. Additionally, trainees are exposed to multiple outpatient clinics, including the Tom Baker Cancer Centre Pain and Symptom Management Clinic, Brain Metastases Clinic, ALS Clinic, as well as Palliative Cardiology and Nephrology Clinics. Academics include four presentations at Advanced Practice Rounds, Journal Club presentations and organization, participation and presentation at Mortality and Morbidity (M & M) Rounds as well as Palliative Grand Rounds. Residents complete a scholarly project, which can lead to
PALLIATIVE CARE

publication, presentations and development of local protocols and educational tools. Graduates of the program are able to provide primary and consultant palliative care services, and leadership in palliative care service delivery, research and education.

The Division of Palliative Medicine also educates a large number of residents from different disciplines, building community capacity for palliative care delivery in primary and specialist care. In 2014-2015, the Division will have trained 121 rotating residents, 74 of which hail from the Department of Family Medicine. Other trainees include residents in Internal Medicine, Oncology, Neurology, Anaesthesia, and Physical Medicine and Rehabilitation. Residents are exposed to palliative care environments such as the Intensive Palliative Care Unit, Inpatient Hospital Consult Services, as well as Home Care and Hospice.

Residents also receive academic teaching through weekly seminars, Journal Club, and rounds presentations. Through these experiences, residents gain greater confidence and ability to provide competent and compassionate palliative care to patients and families in the community as well as in hospital.

UNDERGRAD MEDICINE ELECTIVES

We supervised nine University of Calgary medical students this past year. These experiences included a first year medical student on elective, second year medical students completing Med 440 (evidence based clinical medicine course) and third year clerks taking two week electives with us.

New this year, our palliative medicine division agreed to accept visiting elective medical students and we supervised a total of nine students from other universities (from across the country, University of British Columbia to the University of Toronto). Each student completed a two week elective which included experiences with a hospital based consult team, as well as community experiences in hospice and long term care.

Members of our division also continue to act as preceptors in Course 5 small group teaching on the topics of pain and palliative care.

CONTINUING MEDICAL EDUCATION

The Calgary palliative care group has many opportunities to fulfill their CME requirements that are also approved by the College of Family Physicians as well as the Royal College.

The palliative care fellows present at the Advanced Practice Rounds every month with up to date review of topics such as existential suffering, bowel obstruction and depression. On the first Friday of each month are
journal rounds for the palliative physician group. M&M rounds are held on the last Friday of the month and all of the various programs (i.e. hospice, homecare, consulting teams, Intensive Palliative Care Unit) attend and discuss an interesting patient case to use as a learning opportunity.

**The Calgary Zone Palliative program will once again run the Mary O’Connor conference in May 2015.**
As well, the division of palliative medicine is pleased to host the 11th Annual Advanced Learning in Palliative Medicine conference in May 2015 in Calgary. It’s run by the Canadian Society of Palliative Care Physicians. Many members of the Palliative Care section are involved in the planning committee (Chair: Dr L. Herx; Committee: Dr S. Chary, Dr L. Galloway, Dr A. Murray, Dr J. Simon, Dr M. Labrie) as well as presentations during the conference (Dr M. Slawnych, Dr E. Wasylenko, Dr M. Labrie, Dr A. Murray, Dr A. Abdul-Razzak, Dr S. Chary, Dr R. Spice).

**Provincial Palliative Program**

The AHS provincial Palliative and End of Life team has been working diligently at many initiatives in order to develop a more robust, evidence-based PEOLC program available to all Albertans and promote patient-based care. The Calgary Palliative Care section physician members have been very involved with all of these initiatives. The current list of working groups include Provincial PEOLC Innovations Steering Committee (Dr A. Sinnarajah), Dashboard and Indicators Working Group (Dr J. Simon, Dr A. Sinnarajah, Dr E Wasylenko), Advance Care Planning/Goals of Care Designation Policy Implementation Working Group (Dr J. Simon), PEOLC Strategic Clinical Network (SCN) Pathways & Guidelines Working Group (Dr A. Abdul-Razzak, Dr S. Colgan, Dr L. Herx, Dr G. Ho, Dr A. Sinnarajah), EMS Assess, Treat and Refer Working Group (Dr L. Murphy, Dr A. Sinnarajah), PEOLC Gateway Working Group (Dr S. Chary), Palliative Care and Hospice Capacity Working Group (Dr D. Falk), 24/7 Palliative On-Call Support Working Group (Dr A. Sinnarajah, Dr R. Spice), Business Casing and Strategic Planning Working Group and Volunteer Initiatives Working Group (Dr E. Foster).
**SPECIAL POPULATIONS**

Tom Baker Consult Service

Starting in the summer of 2014, we’ve established a dedicated Palliative consultant presence at the Tom Baker Cancer Centre (TBCC) similar to what already existed for in-hospital and community sites of care delivery across the zone. This represents an expansion of the previous TBCC Pain & Symptom Management Clinic’s scope, in that it allows regular access to palliative expertise five days a week. This has been an excellent opportunity for better integration of the outpatient Cancer Care system with both the community (home care) and acute care (Intensive Palliative Care Unit) aspects of the Palliative Care system in the zone. **We are currently working with 1.0 physician and 0.5 Nurse Practitioner FTEs,** in partnership with Dean England and Chris Ralph, the excellent pain/symptom clinical pharmacists at Tom Baker, and Renee Lee, our nurse coordinator. Dr Lyle Galloway is leading this effort.

We are working to establish a regular “Tumour Group” forum, similar to that which exists for other tumour sites, including representation from Medical Oncology, Radiation Oncology, Pharmacy, Palliative Home Care, Radiology, Psychosocial Resources, and Spiritual Care.

Palliative consultant involvement at TBCC can take the form of:

1. Phone/email/hallway consults,
2. Palliative Consultant presence at Tumour Board rounds,
3. Embedded Palliative Consultant in select oncology clinics (e.g. Brain Mets Clinic),
4. In-person consults, either on-demand for urgent situations, or booked electively for less urgent cases.

**PALLIATIVE HOME CARE**

“To enhance dignity, comfort, and choice through sustainable, specialized palliative care at home”

The Palliative home Care team is a 24/7 service offered to clients at the end of life. It’s one of the programs offered as part of the Palliative & End of Life Care program in Calgary. **Typically clients are referred to the program in the last six months of life and can have a variety of illnesses including cancer, CHF, end stage...**
renal disease, COPD, ALS/MS and dementia. The Palliative Home Care team practices with a client centered, holistic approach. The team consists of 26 geographic caseloads that are managed by Registered Nurses (RNs), and there is also multi-disciplinary and collaborative support from registered respiratory therapists, physiotherapist, occupational therapists, social workers, licensed practical nurses and palliative physician and clinical nurse specialist consultants.

The team provides education, symptom management, goals of care planning, psychosocial support and assists clients with equipment, and financial guidance to support them through their disease trajectory. The RNs collaborate with the larger health care team including the family physician, Tom Baker Cancer Centre or other specialists to coordinate optimal client care. It continues to support a primary medical home by encouraging family physicians to stay involved in the palliative home care patient.

The Palliative Home Care team has a staff of close to 100 palliative experts across a variety of disciplines and covers any referred end of life clients living within the Calgary city limits. On average there are 350-380 clients on the program at any point in time: however, due to the palliative nature of these clients the average length of stay on the program tends to be less than six months and over the past few years has been moving towards three months from admission to client death or hospice transfer. The Palliative Home Care team receives about 80-95 new referrals per month.

The majority of staff work 0830-1645, but the clients have access to the Palliative Home Care Response Team from 1630-0830 seven days a week. This small team provides urgent symptom management, end of life support, psychosocial support and can facilitate on-call physician access for clients and families who are in distress. This can be in the form of either a home visit or telephone support. There are two RNs on evenings and one RN on nights that provide this support to all Palliative Home Care clients and all Rural Home Care clients who are considered palliative. They are also available as consultants to support any clients on Integrated Home Care who require palliative expertise.
Palliative Care

Leadership

Many members of the section are taking on leadership roles by participating in many local, provincial and national medical committees related to palliative care primarily but also other medical areas. Some highlights (not already mentioned in other parts of the report) include:

Dr Ted Braun has many key leadership positions within AHS including Acting Associate Zone Medical Director and Medical Leader for Public Health, Primary Care, Chronic Disease Management and Allied health all for the Calgary Zone.

Dr Srini Chary is the Chair of the Pallium Foundation of Canada, which is involved in national educational activities related to palliative care. It has a $3 million funding from the Federal Economic Action Plan 2013.

Dr Marisa Dharmawardene is on the FMC Site Leaders committee as well as the Residency Program Committee. She was also an invited speaker at the Harvard School of Public Health.

Dr David Falk is involved in the DFM residency program as Domain Lead in Palliative Care, attending monthly Curriculum Evaluation Committee, FMRPC meetings, Domain Lead meetings, meetings with Care of the Elderly lead and meetings with hospice preceptors. Next step is to help out with the evaluation of curriculum and resident assessment process.

Dr Eleanor Foster is on the Palliative Home Care Quality Improvement committee. She made a couple of palliative care presentations at the 35th CDMA Continuing Medical and Dental Education Conference in Thailand in 2014.

Dr Lyle Galloway led a presentation on the use of neuraxial analgesia in Calgary at the 25th Annual Palliative Education and Research Days in 2014.

Dr Leonie Herx on the working group that is creating the new Royal College of Physicians and Surgeons of Canada's Palliative Medicine training program as well as being on the Board of the Canadian Society of Palliative Care Physicians.

Dr Hubert Marr is a member of the PLC Ethics committee and will make presentations at the Calgary Hospitalist conference as well as the Canadian Bioethics Society annual conference.

Dr Alison Murray led a presentation on the use of Denosumab in palliative care at the 20th International Congress on Palliative Care in 2014. She was also the runner-up when she presented on Managing End of Life Symptom Crises in the Home at the 10th Annual Advanced Palliative Medicine Update in 2014.

Dr Sara Pawlik is our Palliative Medicine Residency Program Director and recently successfully had our residency program accredited.

Dr Jessica Simon has made many presentations on palliative care and advance care planning both to residents as well as family physicians (Lunch and Learn). She also sits on the National Advance Care Planning Task Group and the Canadian Hospice and Palliative Care Association. She co-authored the Choosing Wisely Canada palliative care list. She was also promoted from Assistant Professor to
Associate Professor at the University of Calgary within the Division of Palliative Medicine, Department of Oncology.

Dr Aynharan Sinnarajah sits on the Alberta Scientific Assembly Planning Committee and Nominations/Awards Committee of the Alberta College of Family Physicians. He is also a member of the Clinical informatics team for AHS Calgary and co-chairs the Electronic Laboratory and Diagnostic Imaging Advisory Committee. He also completed a Master’s in Public Health degree at Harvard University in 2014.

Dr Eric Wasylenko is the Medical Advisor of the AHS Provincial Advance Care Planning/Goals of Care Designation Initiative, Ethics and End of Life Care Consultant for Health Quality Council of Alberta, Chair of the Public Health Ethics Consultative Group of Public Health Agency of Canada. He has made numerous presentations over the year to various groups on ethics, advance care planning, and physician assisted suicide.
At times, it can seem that cancer is surrounded by powerful words and strong language. But one word that’s hard to come to terms with is “palliative.” For many, it implies the end of life, surrender. It’s a word that individuals living with cancer, their families and their health-care teams, struggle to raise in conversation.

Yet it’s a word and a conversation that are essential to those whose cancer continues to advance and requires complex medical care, and for those who are facing the end of their life. According to the World Health Organization, palliative care is a dimension of care “that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”

“While the definition of palliative care is supportive, in reality few of us are ever prepared to hear that our life will end,” says Bert Enns, a spiritual care specialist and project lead at the Tom Baker Cancer Centre and Calgary Zone Palliative Care Collaborative. “Life is precious. As healthcare providers, we face a dilemma. How can we explore palliative and end-of-life care in a gentle and timely way to ensure that people have the necessary support through one of life’s most challenging transitions?”

Alice Campbell, a retired nurse who has been living with cancer for several years, remembers the first time she heard the term “palliative” in relation to her care, in 2009. “As I woke up from a surgical procedure, the nurse co-ordinator told me I was being referred to the palliative home-care team. I recall how frightening that was. No one had told me that I was dying.” The palliative care team was uniquely qualified to deal with a case as complex as Campbell’s. “I needed that specialized care but my goal was to recover,” she says. Recover she did. “That word, palliative, is loaded emotionally and for most patients and families, it indicates that their loved one is dying,” she says.

To her way of thinking, the word palliative covers intricate cancer care on a spectrum, including people who will graduate from care and those who are terminally ill and will progress toward the end of life with the support of a palliative team the entire way. When she was diagnosed with stage four non-Hodgkin’s lymphoma in 2009, Campbell’s doctor told her there was no cure. “It’s a very hard conversation when your doctor says, ‘This cancer’s not going away. You can count on it coming back but when it does hopefully we will have a new treatment.’” With the most recent reoccurrence, Campbell was told she could access palliative care again, if and when she needs it.

According to Enns, recent research has identified the benefits of an early palliative approach. By working with individuals and their families, health-care professionals can help patients access a multitude of services for their physical, emotional and spiritual well-being. With this support, patients can make decisions that reflect their values and personal goals for living with
PALLIATIVE CARE

cancer, including the last stretch of life. For example, incorporating a palliative approach into care can ensure that quality of life issues are integrated into discussions regarding treatments at the point of diagnosis. If treatments are not successful and cancer advances, appropriate supports are added to ensure symptoms are well managed and decisions regarding treatments continue to reflect an individual’s priorities and values. Patients need to be well informed about treatment options and services available at all points of their journey with cancer.

Enns is leading a two-year project, funded by the Alberta Cancer Foundation, to enhance the care for Tom Baker Cancer Centre patients and their families in the Calgary Zone. The project examines current services and identifies gaps and opportunities for best practices required to integrate an early palliative approach to care. Despite Calgary having one of the best-resourced and utilized palliative care programs in the country, there is recognition that cancer patients and their families are not always accessing these services in a timely manner.

In Phase 2 of the project, the committee will develop pathways that guide patients, families and health-care teams to ensure these conversations about care decisions and resources are proactive and enhance the integration of palliative services. To better integrate early access to palliative care, the committee will develop pilot opportunities to address current gaps. It will also develop educational resources that support health-care professionals to have these difficult early conversations.

The challenge is clear. What’s the best way to introduce palliative care to ensure its entire scope is provided? Is it a term that can become acceptable and supportive without diminishing a patient’s sense of hope?

“We recognize we have work to do and are committed to finding better ways to integrate an early palliative care approach into all aspects of our cancer care,” says Enns.
Palliative Care

Facts

Overall Utilization by Program
April 2013 - March 2014

Alberta Health Services, Calgary Zone Palliative Consult Teams
Unique Patients Served By Fiscal Year 2002/03 - 2013/2014
Palliative Care

Alberta Health Services, Calgary Zone
Hospice Admissions from Community and Acute Care By Fiscal Year

Hospice Discharge Status (2013/14)

- Deaths 94%
- Discharges 6%
PALLIATIVE CARE

Alberta Health Services, Calgary Zone Hospice Occupancy Rates by Fiscal Year 2007/08 - 2013/14

AHS, Calgary Zone, Average Days on Waitlist for Those Admitted to Hospice 2010/11 through 2013/14 Fiscal Years
Advance Care Planning & Goals of Care Designation
Telephone Chart Audit & Survey

Who was included?
The majority of respondents were familiar with ACP, GCD, and Green Sleeves when prompted with a definition.

What did we find? - Survey

Familiarity with...

<table>
<thead>
<tr>
<th></th>
<th>Unprompted (%)</th>
<th>Prompted (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACP</td>
<td>21</td>
<td>90</td>
</tr>
<tr>
<td>GCD</td>
<td>35</td>
<td>64</td>
</tr>
<tr>
<td>Green Sleeve</td>
<td>31</td>
<td>68</td>
</tr>
</tbody>
</table>

What did we find? - Chart Audit

- 65% had conversation
- 10% satisfied with conversation
- 77% were able to find ACP, GCD, Green Sleeves

Alberta Health Services, Calgary Zone
Consult Teams & IPCU Average Daily Caseload
2013/14
CHALLENGES

Overall, the challenges continue to be recruitment to all the funded positions of the clinical ARP for the palliative physician consultant role. This has led to many physicians working more than their contracted amounts in order to ensure that the palliative care service is always staffed. We will be looking to hire the current two palliative fellows which should allow us to improve staffing. Currently, there are job postings and our recruitment and selection committee is looking to recruit more physicians.

Last, but not least, the recent Supreme Court of Canada decision that has allowed for the possibility of 'Physician Assisted Death' has implications for the palliative care physician group. Discussions are ongoing within the group as well as with AHS to advocate and collaborate on next steps.

Tom Baker Consult Service

The main challenges to date have related to the limited clinic space/time available in the current Cancer Centre, but this has not proven to be hugely restrictive. In many cases, the service has been able to see patients in their primary oncology clinics or while they're receiving chemotherapy or radiation treatments. This approach represents more convenience for patients/clinic staff, better visible integration of palliative expertise into normal Cancer Centre operations, and minimizes number of separate appointments required in a system that is struggling to economize time and space usage.
Hospices

Foothills Country Hospice in Okotoks main challenge continues to be the need to raise operational funds.

QUALITY ASSURANCE, QUALITY IMPROVEMENT & INNOVATION

ADVANCE CARE PLANNING/GOALS OF CARE DESIGNATION (ACP/GCD)

Ongoing Quality Improvement activities are complimented by the team actively contributing to research in ACP. For example, Dr H. Wrigley, Calgary Primary Care Physician, has just completed a study with Dr Simon looking at patient-rated acceptability of the Conversations Matter Guidebook provided at admission to acute care. Dr Simon co-leads the Alberta Innovates Health Solutions Collaborative Research and Innovation Opportunities Program grant on ACP (www.ACPCRIO.org), which completed year two of the five year study in April 2015, yielding insights into local barriers, facilitators and readiness for further uptake of ACP GCD.

INTENSIVE PALLIATIVE CARE UNIT

There are now two new therapy programs that are being piloted on IPCU for patients and families centering on art and music. The Alberta Cancer Foundation has provided funding for the Healing Arts Program for a two year pilot project 2014-2016. Through this grant, IPCU receives a dedicated art therapist for one half day per week. In addition, there are a number of other art therapy programs being offered through the Tom Baker Cancer Center that our IPCU patients can participate in, including Healing Arts in Medicine, Healing Arts Music Therapy and a Therapeutic Doll Making Workshop. There is also a dedicated music therapist on IPCU for one day per week through the support of a six month grant from the Canadian Music Therapy Trust Fund for harpist Jan Pearce. Data will be collected from these two pilot projects that will allow advocacy for ongoing funding for these important programs.

The IPCU is currently developing best practice unit-specific medication protocols for all clinicians to access electronically, including guidelines for use of infusions for ketamine, lidocaine, midazolam, as well as methadone rotations. This is a collaborative project between the clinical pharmacists, physicians and nursing educators. We continue to adapt to ongoing AHS initiatives such as the new procedural sedation policy, whereby our physician team is undertaking additional training to ensure patient safety and optimized patient care, and we are engaged in ongoing dialogue regarding the role of IPCU in the new cancer centre.

PALLIATIVE HOME CARE

Some recent quality improvement and innovative accomplishments for the Palliative Home Care Team in the last year have included the roll out of the provincial End of Life assessment, Care Planning and Medication Reconciliation to ensure consistent, standardized documentation that is all entered directly into the electronic health record.
PALLIATIVE CARE

HOSPICES
The Hospice Transfer of Information Quality Improvement Project was launched in 2014. It is grounded in the Alberta Improvement Way process and supported by an AHS Quality Improvement Specialist. Steering committee includes stakeholder representatives from all Calgary zone hospices, Hospice Medical Directors group, IPCU, Palliative Home Care, AHS Palliative Consult Service (MD & CNS), Hospice Access, and AHS PEOLC Medical Director. The goal of the project is to identify/ create sustainable resources and processes to ensure efficient and effective transfer of information when patients are admitted to hospice from home or acute care sites.

FUTURE DIRECTIONS
For the Tom Baker Consult Service, opportunities for growth moving forward are:

- Discussions about the role of a Provincial Palliative “Tumour Team”
- Integration with the current medical/radiation oncology fellowship training programs to allow outpatient palliative/symptom consult experience
- Research possibilities in the outpatient cancer setting
- Role in education regarding primary palliative care for existing outpatient clinics

Our on-the-ground clinical operations are occurring at the same time as the Alberta Cancer Foundation-funded Calgary Zone TBCC and Palliative/End-of-Life Collaborative Project, under the leadership of Bert Enns, continues its important work to define needs and make recommendations for future growth and development in this area. Both teams continue to benefit from sharing of information and ideas as we take this work forward.

The Collaborative Project was recently profiled in the LEAP Magazine, Winter 2014 titled "Bridging the Gap: Integrating a palliative care approach within cancer care". Several of our section members are involved in this important project including on the Management Committee (Dr Aynharan Sinnarajah), and Advisory Committee (Dr Jessica Simon, Dr Srini Chary and Dr Lyle Galloway. With permission from the LEAP magazine, snippets from that article are shown in the Special Populations section.

The palliative home care is in the midst of a quality assurance project underway looking at the impact of the after-hours team in regards to client support and decreasing distress and emergency visits.

The palliative consult teams, palliative home care and hospices are involved in a Palliative and End of Life Care quality improvement project "Hospice Information Transfer Project" to ensure that the program is optimizing transitions for our patients and families who are transitioning from the various inpatient and community sites to the various hospices in Calgary. This started officially in early 2015 and will be ongoing through the year.

The provincial 24/7 Palliative On-Call initiative was successfully rolled out in Calgary as of April 1 2015, where community physicians can now more easily access the palliative physician on call service for
urgent phone consultation. We partnered with the RAAPID service (Referral, Access, Advice, Placement, Information & Destination) to improve this access.

Calgary has had an EMS protocol to allow palliative patients at the end of life to access medications on an urgent basis without needing to go into hospital for a few years. With the province implementing this protocol this year, Calgary will be looking to expand this to include the rural areas of the Calgary zone, as well as palliative patients who aren’t already in palliative home care. This should lead to improved patient care by allowing them to stay in the community longer.
HIGHLIGHTS & ACCOMPLISHMENTS

CURRENT CAPACITY

There are 7063 continuing care beds in the Calgary Zone. In the next three months, 413 Supportive Living beds are slated to open, then a further 194 beds (including 30 Long Term Care beds) are scheduled to open by the fall of 2015. There are currently 710 people waiting for a Continuing Care bed, with 275 waiting in Acute Care and Sub-acute care as of April 28, 2015. This shortfall is significantly impacting Acute Care capacity. The announcement of the revised Continuing Care policy is anticipated in the spring of 2015. It is hoped that this announcement will further strategies for easing the shortfall of available continuing care beds.

CONTINUED PHYSICIAN RECRUITMENT

Alberta Health approved an expansion to the “Frail Elderly” ARP as of August 2014. It included physician clinical support for an additional 14 Long Term Care and 7 Supportive Living sites. To date, recruitment efforts have been successful for these positions.

It has been challenging to recruit physicians to provide onsite care in Supportive Living sites. While some patients choose to stay with their own family physician maintaining continuity of care there are many patients who are physically unable to leave the facility. Recruiting physicians to provide onsite care to these patients is progressing slowly.

We have successfully recruited three Long Term Care Medical Leads this year: Dr. Thomas Bouchard, Father Lacombe Care Centre; Dr. Bunmi Oyebanji, Bethany Care Society; and Dr. Yasmin Majeed, AgeCare.

Work continues to support physicians on site in Continuing Care by regularly meeting with a core group by mentoring and encouraging other strategies for leadership development including PMI courses.

APPROPRIATE USE OF ANTIPSYCHOTICS

The Seniors SCN began a project regarding the appropriate use of antipsychotics. This pilot has been rolled out through Long Term Care and Supportive Living sites throughout the province. The SCN is currently evaluating the project and outcomes to date have shown how effective it has been at decreasing the use of antipsychotics in the elderly with the Calgary Zone use
being lower than the provincial average.

**Community Paramedic Program**

The Community Paramedic Program continues to be successful and we have found it to be a promising collaboration to provide care in Supportive Living and Lodges. This program is expanding into Long Term Care sites in 2015. We also hope to expand awareness of the program amongst family physicians in the community.

A pilot project has begun at Garrison Green to provide IV therapy to patients to prevent hospital transfer and admission. Onsite family physicians provide support to paramedics as the Most Responsible Physician.

**Continuing Medical Education**

The Geriatrics Update was held in October 2014 and was extremely successful. Plans for 2015 have already begun.

Friday at the Medical School – Introduction to Long Term Care for the Family Physician and Nurse Practitioner will be held in May 2015. Information will be provided on the management of dementia, wound care, falls prevention, end of life care, pain management, and the appropriate use of medications in the elderly.

**Future Directions**

**Access to Netcare**

The access to current patient information on Netcare on-site is not easily accessible for physicians in contracted sites to AHS. This issue has been escalated and will be addressed at a senior administrative level. AHS has disseminated an Expression of Interest for the development of an Alberta Netcare Portal for AHS affiliated sites. It is hoped that successful implementation will allow physicians to access patient health information Continuing Care sites.

**Provincial Dementia Strategy**

Through the Seniors SCN, the Seniors section is currently involved with the Primary Care Working Group for the development of a provincial dementia strategy. The strategy will eventually be rolled into a national dementia framework to be completed later in 2015.
QUALITY ASSURANCE, QUALITY IMPROVEMENT & INNOVATION

We are currently collaborating with Alberta Health Services, Carewest and private care centres to develop a QI project on complex patient populations especially those with difficult behaviors.
COMMUNITY PRIMARY CARE

ACCOMPLISHMENTS & HIGHLIGHTS

Physician Web Registry
The DFM partnered with the PCN Secretariat to develop a Physician Web Registry (www.calgaryfamilymedicine.ca) that is a searchable database of physician contact information for use by health care professionals for discharge planning and referrals. The website is searchable by name, city quadrant, clinic name or address, city or town, or postal code. The website also enables searches by PCN with a full list of physicians for each PCN. The response to the web registry has been overwhelmingly positive and has furthered the data sharing relationship between the DFM and AHS.

Further communication to AHS acute care leaders is planned for the next year to disseminate information about the web registry within the organization. An evaluation framework including metrics on web usage is also planned.

DFM HomePage – E-newsletter
A bi-weekly e-newsletter, DFM HomePage, was launched by the DFM in November 2014. The DFM HomePage is sent to over 1000 subscribers including all DFM privileged physicians. The e-newsletter has created a connection to family physicians for quick information that will benefit their practice including information on CME, events, and new programs and services. The majority of emails are opened within 48 hours with over 50% of the emails opened from a mobile device.

Further plans to improve DFM communication vehicles include updating the Calgary Family Medicine website (www.calgaryfamilymedicine) and the AHS DFM website (www.albertahealthservices.ca/4011.asp). In the next year a three times/year print and web publication will be developed that will provide updates from each of the Sections and information about the DFM strategic plan.
COMMUNITY PRIMARY CARE

48th Annual Mackid Symposium – June 2014

For 48 years, the Mackid Symposium has provided a day of exceptional continuing medical education for family doctors and general practitioners in Calgary, however, the premier CME event for primary care doctors in the Calgary Zone has evolved. It has now become the educational ‘destination’ for organized Primary Care in our zone. In partnership with the Calgary Zone Primary Care Networks, Family Care Clinics and the University of Calgary Office of Continuing Medical Education and Professional Development – the focus has shifted to the entire primary care health team: Physicians, Nurse Practitioners, Pharmacists, Nurses, Psychologists and the rest of the services providers in the patient centered medical home. The ‘target audience’ for this program includes the 1300+ family physicians and the hundreds of other team members working with them.

The theme of the 2014 program – Mental Health in Primary Care - is a topic that arose from a grass roots expression of need for further education in this important and challenging area. The symposium featured an expansion of the traditional day long program to include an evening program devoted to Depression. In addition, two learning streams are offered which are tailored to different levels of confidence, knowledge and level of care including a needs assessment to help participants to decide on an appropriate stream. The DFM engaged a number of community and AHS resources to help practitioners connect to appropriate resources.
East Calgary Family Care Clinic
The East Calgary Family Care clinic is mandated to serve complex patients with chronic disease, psychological or social challenges. The complexity of this patient population makes the traditional medical home model difficult to employ.

Client Attachment and Service Event Summary

Sample – Data was extracted from the East Calgary Family Care Clinic (ECFCC) electronic medical records (EMR) appointment and medical chart applications. Service event counts were collected from appointments between April 1, 2014 and March 31, 2015. They included all client-provider interactions such as face-to-face and phone consultations. As of summer 2013, clients were attached to a specific primary care provider (PCP) medical doctor or nurse practitioner at the ECFCC. These PCP attachment and unattached panels were collected on May 6, 2015. Panel size for one provider was not available for collection due to an error within the EMR. This provider’s panel size was estimated based on a panel data collection from Nov, 2014.

Number of client service events at the ECFCC between April 1, 2014 and March 31, 2015

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Number of Client Service Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD (4.5 FTE)</td>
<td>10,714 (35.54%)</td>
</tr>
<tr>
<td>NP (3.3 FTE)</td>
<td>6,404 (21.25%)</td>
</tr>
<tr>
<td>Other Providers *(11.2 FTE)</td>
<td>13,025 (43.21%)</td>
</tr>
<tr>
<td>Total (14.2 FTE)</td>
<td>30,143</td>
</tr>
</tbody>
</table>

Distribution of attached and unattached clients at the ECFCC as of May 6, 2015

<table>
<thead>
<tr>
<th>Primary Care Provider Type</th>
<th>Number of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>2,547 (35.61%)</td>
</tr>
<tr>
<td>NP</td>
<td>1,576 (22.04%)</td>
</tr>
<tr>
<td>Unattached</td>
<td>3,029 (42.35%)</td>
</tr>
<tr>
<td>Total</td>
<td>7,152</td>
</tr>
</tbody>
</table>
COMMUNITY PRIMARY CARE

*Other providers include: mental health therapists, social workers, physiotherapists, registered nurses, pharmacists and dieticians

Find a Doctor Web Registry
This year the PCN Secretariat invested in the revamp of the Find a Doctor website, www.calgaryareadocs.com. The project is a collaboration between the seven Calgary and area PCNs and other partners including the DFM. The revised website will go live June 1, 2015. A public launch will be held later that month.

The new site offers patients a quicker and more efficient method of finding a family physician in the Calgary area (including surrounding rural communities). The site features an interactive map and patients can search areas by address and also narrow their search by physician gender and languages spoken, for example. The original Need a Doctor service in which patients filled out a form and asked a PCN to connect them with a physician will still continue as an option on the new site.
Medical Home Working Group
The Medical Home Working Group had several accomplishments this past year:

Access

- Public health and PCNs partnered to increase access to breastfeeding support. This partnership developed an algorithm which increased access to lactation consultants and procedures by building capacity for anterior frenotomies.
- Emergency Department Referral Project - this project is with Calgary Foothills PCN and Foothills Medical Centre and Rockyview Hospital and Calgary West Central PCN. Patients presenting in ED, who meet criteria, are approached by the ED nurse to see if they are interested in being referred to a PCN clinic. The goal of the partnership is right level of service for issue presented.
- The group has prioritized coordinated barrier-free access for a 2015 project.

Attachment

- The Working Group developed an attachment algorithm for a Pediatric Kids in Care (PKIC) partnership. Each PCN has committed to connect these children with their foster and/or bio family to a family physician. The algorithm is also supporting Path to Home for patients discharged from hospital.
- We have also organized activities to support panel developments. We have a Sharepoint site for all PCNs to share documents, videos, etc. The site is organized in change management theory. We organized a Deeper Dive session on April 23rd to share panel practical tips, strategies, etc.
Happiness Basics/Mental Health

Happiness Basics is a seven week series that will teach skills to people 16 and older to live a happier life. Happiness is a state of mind that must be chosen and reinforced with action on a daily basis. Backed by the latest positive psychology approaches, Happiness Basics helps participants build the skills they need to increase the amount of positive experiences, engagement, meaning and opportunities for achievement they have in their lives. Taking part in this workshop, which was initially developed by the Red Deer PCN, has been shown to improve participants’ mood, vitality and energy, as well as their physical and mental health.

Through the Mental Health flood funding, the Calgary Zone launched a partnership with Red Deer PCN to bring Happiness Basics to our area in hopes of offering something that could help people build resiliency through any natural disaster. Mosaic, Foothills, Highland and Bow Valley PCN's sent facilitators to be trained in June/July 2014 (training was brought to Calgary to help leverage the Calgary Zone Pan-PCN opportunities). In the fall of 2015, the four PCNs above started offering Happiness Basics in each of their areas. Each PCN has their own successes and challenges and the move forward for the pan-PCN group is moving forward to develop a coordinated evaluation strategy and cross PCN registration process as well as continue to offer and refine the program.

Specialty Linkages

The Calgary Zone Primary Care Secretariat consists of representatives from all Calgary PCNs including Calgary Rural, Highland and Bow Valley PCNs as well as DFM and AHS Primary Care. The Secretariat was tasked with looking at primary care issues in the zone which may benefit from a Pan-PCN approach.

The Health Systems Support Task Group began to look at issues around the connections between primary care and specialty care. These connections were divided into two discrete pathways:

1) Path to Care – a patient’s journey from their medical home to specialty care
2) Path to Home – a patient’s journey from specialty care to their medical home

The medical home is defined as where the patient receives their continuous and comprehensive primary medical care.

Path to Home Discharge Pilot Project

With this project communication gaps are being addressed with notice of admission and notice of discharge sent to family physician when their patient is admitted to and discharged from acute care.

The pilot is on 12 medical units at the Foothills Hospital. Staffing consists of two clerks currently funded by Calgary Foothills PCN (CFPCN) and managerial support from CFPCN.
Community Primary Care

Clerks are faxing information to the medical home using the DFM Physician Web Registry which provides the most up to date list of family physicians in the Zone. In addition to admission and discharge information the clerks are identifying patients admitted to any of the 12 units that are unattached. Once identified the PCNs have agreed to receiving patients in their postal code and using internal processes to ensure the patient is seen within seven days of discharge and ultimately attached to a medical home.

In the first four months of the pilot there have been only 30 patients who were unattached at admission. 15 patients were referred to the appropriate PCN and the other 15 patients had complicating factors that made it difficult for the clerks to initiate an attachment process.

The pilot at the Foothills Hospital has been very successful and the program will continue beyond the pilot. The next goal is to expand the service to the majority of inpatient units at the Foothills.

The Rockyview Hospital “Path to Home” pilot is currently hiring a clerk to begin similar notification, discharge and attachment processes in the very near future.

A similar project at the South Health Campus involving unattached emergency patients and the South Calgary PCN is a success with all patients needing requiring care from the South Health Campus ER being seen within seven days by a primary care physician.

Appropriate follow-up of patients after discharge from acute care and attachment of unattached patients to a medical home is an ongoing priority of Calgary zone PCNs.

Path to Care

Access to specialty care continues to be a major challenge in the Calgary Zone. Specialty linkages were identified as a key area that would benefit from a Pan-PCN approach.

The first specialty group to work with the Health Systems and Support Task Group was Gastroenterology. Gastroenterology was among the top five specialty groups named by PCN physicians as causing frustration when attempting to access care for their patients. The Department of Gastroenterology was highly motivated to improve access to care and work with primary care to find solutions.

Some key guidelines for the working group included sharing information openly in a respectful manner and using the referral process as an opportunity for education. An initial joint success has been the launch of Specialist Link. It is a shared initiative between the Department of Gastroenterology and Calgary and area PCNs. A GI specialist will return a family physician call within 30 minutes for a real
COMMUNITY PRIMARY CARE

time consultation. It is available Monday to Friday from 8 till 5 pm. Specialist Link is a new link in the chain of patient care.

Specialist Link has been extremely well received with over 67 calls in the first three months. It provides the opportunity to develop a relationship between primary care and specialty care that is responsive and collegial. Over a third of the calls have allowed the patient to continue to be cared for in the medical home and no referral has been required. Specialist link will continue as a joint initiative and as more specialty linkages are forged the service will hopefully expand to continue to meet the needs of our patients.

Other work to support the linkages in GI include enhanced primary care pathways for patient care, supporting the medical home before referral with education, and community options for patient care. Discussions with other specialty groups for path to care linkages are beginning very soon.

The GI-PCN Collaboration was recently nominated for the third annual Alberta Health Services President’s Excellence Award.

Alberta Referral Pathways
www.albertahealthservices.ca/pathways

Alberta Referral Pathways is a collaborative provincial initiative that aims to improve patient care transitions through the health system by determining what is required on a referral, what services are available and what can be done to create clear and consistent referral experience for patients and care providers. To involve care providers and services from every point of a patient’s journey through the health system, the AHS Provincial Access Team is collaborating with the DFM, primary care physicians, specialists, Strategic Clinical Networks, Primary Care Networks, and the Alberta Medical Association to lead referral transformation and develop provincial referral pathways. Upon pathway completion, each specialty will have:

- Standard referral requirements
- Robust referral and consultation processes
- Transparent wait times
- Provincial access targets

With the support from clinical leads, adult gastroenterology, pediatric gastroenterology and pulmonary services completed their referral pathways in the past year.

- Provincial Gastroenterology (Adult) Referral Guidelines provide comprehensive inpatient, ambulatory and emergency care for adults with gastrointestinal and liver diseases.
Community Primary Care

- Provincial Gastroenterology (Pediatric) Referral Guidelines provide care for children between birth and 18 years of age with intestinal, liver and complex nutritional disorders. The pediatric gastroenterologists work collaboratively with other disciplines (e.g. Pediatrics, Nutrition Services, Feeding and Swallowing Services, Provincial Pediatric Weight Management Program) to provide the most appropriate disease management.

- Pulmonary Central Access & Triage provides services for adults with acute and chronic lung diseases.
Outstanding Family Physician of the Year 2014

The 2014 OFP award selection committee was tasked with reviewing nominations submitted by patients and colleagues applauding the quality of patient care family physicians provide. In total 85 physicians in the Calgary area received nominations with a number receiving multiple nominations.

The Department of Family Medicine was proud to announce two award recipients of the Outstanding Family Physician Award for 2014 **Dr. William (Bill) Hall** and **Dr. Thomas Bouchard**.

As a family physician with a long time practice in Calgary it is not surprising that the individual who nominated Dr. Hall recalls meeting him as a child and now as an adult his entire family is part of Dr. Hall’s practice. In addition to his community practice Dr. Hall has also had a long standing connection to teaching and has held several positions with the University of Calgary’s Department of Family Medicine. He is currently a Clinical Associate Professor with the faculty. As a member of the Calgary Foothills Primary Care Network he served as their Medical Director until 2013 and is currently the co-Chair of the Calgary Zone Primary Care Secretariat. He has also sat on various committees with Alberta Health Services and its former entities as well as the College of Physicians and Surgeons of Alberta. He has also served as a member of the Surgery Test Committee for the Medical Council of Canada.

As a member of our Maternal Newborn Section since 2012 **Dr. Bouchard** has been delivering babies out of the Rockyview Hospital and more recently the South Health Campus. Providing primary care in long term care centres is also another interest of Dr. Bouchard as he will be working on clinic project that will bring a sense of “home” to his long term care and elderly patients. In addition to his work in low risk obstetrics and working with seniors Dr. Bouchard also has a family practice with the Deer Valley Family Medicine Clinic. Dr. Bouchard completed both his medical degree and residency at the University of Calgary. This past year Dr. Bouchard was appointed a clinical lecturer with the University of Calgary and continues his clinical research on hormonal factors related to fertility.
COMMUNITY PRIMARY CARE

CHALLENGES

Recognizing the diverse nature of primary care in the Calgary Zone, work force planning continues to be a challenge. Specifically, it is important to understand the various ways that patients seek and receive medical care. With this in mind, we are trying to understand how many patients are truly "unattached" and the factors that come in to play that lead patients to not "attach" to a Medical Home.

Continuing to look at Medical Home model, a lot of work is being done in the area of Panel Identification in Family Practices. Challenges continue in providing patients with 24/7 care within the medical home. However, various strategies have been developed to look at supporting this care: there is ongoing collaboration with Health Link and a pilot project with Foothills Hospital Emergency Department and Calgary Foothills PCN to ensure that patients with primary care concerns may have these addressed within the Medical Home.

Specialty linkages and long wait times for patients to be seen by specialists also continues to be a challenge in the Calgary Zone. With this in mind, Primary Care and Specialist groups are collaborating to look at innovative ways to meet some of these needs. One example of this is the development of Specialist Link: a telephone consultation service with gastroenterology with the goal of expanding to other areas of specialty care.

FUTURE DIRECTIONS

Community Primary Care continues to look at ways of trying to improving communication, particularly during transitions in and out of the Medical Home. It is recognized that this communication is key to patients receiving quality, timely and safe patient care.
Academic Family Medicine
ACADEMIC FAMILY MEDICINE

FACULTY DEVELOPMENT

The Department provides Continuing Professional Development to over 400 family physicians in the Calgary Zone who are actively teaching.

CPD EVENTS AND WORKSHOPS

Grand Rounds
- One hour monthly to encourage and share scholarship, teaching skills, clinical practice innovation
Fall Together
- A one day Faculty Development conference held annually for all Family Physician preceptors in Calgary Zone and Southern Alberta
Home Room Series
- A series of half day Faculty Development events held approximately three times per year designed specifically for urban Family Physicians who teach in FM Home Clinics
Introduction to Health Research Methods
- Online course (including webinars, small group online discussion and presentation) developed and offered in cooperation with the Office of Continuing Medical Education and Professional Development, Alberta Health Services and Community Health Science, offered Jan to May 2015
Cabin Fever Conference
- An annual three -day Faculty Development conference designed specifically for rural preceptors; hosted by U of C Distributed Learning and Rural Initiatives and co-sponsored by the Department of Family Medicine
Biostatistics Workshop – September 19, 2014
- A one day biostatistics course was offered in cooperation with the Continuing Medical Education Department, Alberta Health Services and Community Health Science
The Foundations for Academic Research Podcasts Suite
- Series of 14 podcasts held at the FM Department website created to provide family physicians with key information to help develop research skills and to reach their scholarship goals
Skill Training Activities – WISE 1 Course; January 22-23, 2014
- The course was offered in collaboration with the Simulation Mentorship Program. It provided training in simulation activities and course developing
CPD Section of the FM Department Website
- It provided useful information and links for related courses and presentations and tools and videos for teaching procedures
- Physicians also used online subscriptions to teaching websites that were provided for their use
- An online bulletin offered specific information about upcoming activities, teaching books online and tools to facilitate teaching or to develop new skills
Family physicians continue to contribute substantively at all levels of governance and curriculum delivery in the University of Calgary medical school.

- Dr. Maureen Topps, Associate Dean Post-Graduate Medical Education; Dr. Doug Myhre, Associate Dean for Distributed Learning and Rural Initiatives; Dr. David Keegan, Department of Family Medicine Undergraduate Director; Dr. Martina Kelly, Department of Family Medicine Clerkship Director and Dr. Johan Bester, Department of Family Medicine, Assistant Clerkship Director.

- Introduction to Clerkship, Family Medicine Clinical Experience, Physical Examination Course and Evidence Based Medicine Course

- MDCN 330, 430 and 440 teaching in UCMC clinics, and urban and rural community clinics

- Family Medicine and Rural Medicine Interest Group support

- The Master Teacher Program continues to be led by family physician Dr. Heather Baxter and 12 of the 30 contracted physicians with the medical school are family physicians. Teaching and leadership in all systems-based pre-clerkship courses are provided by Master Teachers.

- In total, more than 200 community-based and academic physicians provide teaching in the UME curriculum.

- Many preceptors teach in courses such as Global Health and Population Health (in topics such as Aboriginal Health, Addiction & Homelessness, Immigrant & Refugee Health, and the Elderly population) and work with students in the Undergraduate Global Health Stream. Often family medicine UME preceptors are active in mentoring and contributing to medical student initiatives such as the Student Run Clinic (with sites at Inn from the Cold, the Alex and the Mosaic Refugee Health Clinic) and Women’s Health Interest Group.

- The percentage of medical students at the University of Calgary choosing Family Medicine as their career has increased steadily since the all-time low in 2008. The 2014 CaRMS match results indicate that we have now surpassed Canada’s national average.
FAMILY MEDICINE/RURAL MEDICINE INTEREST GROUP

The Department of Family Medicine is a proud co-sponsor of this medical student group. Our roles are to liaise between the Department and students interested in family medicine, to provide information to interested students, and to support medical students with interests in pursuing a career however we can. This year’s executive was particularly well-organized and active; urban and rural skills days, clinic visits, punctuated a year that included a well-attended December 2014 provincial family medicine issues panel. The annual handover document put together by previous groups has proven to be an invaluable resource as new executives come on board each year.

MEDZERO

Medical students turned out in record high numbers to be welcomed via teleconference by University of Calgary Chancellor, former Canadian astronaut and family physician Dr. Robert Thirsk. In all, 143 of 155 (95%) of incoming medical students participated in this consistently popular event that traditionally takes place the day before medical school begins. Clinical preceptors from academic and community clinics helped
deliver the ever-popular hands on workshops in casting and suturing. The suturing workshop was delivered in the brand new ATSSL lab at the Health Sciences Center. This new lab uses the latest communications technologies to optimize learning experiences for large groups in this state-of-the-art teaching facility. Students enjoyed opportunities to network with their colleagues and learn from our best faculty members who volunteered to help out at the event.

New for the coming year we are expanding the workshop offering following consultation with the Family Medicine and Rural Medicine Interest Group. New workshops for this year include: Labor and Delivery led by Dr. Heather Baxter and Vitals led by Dr. David Keegan.

**Family Medicine Clinical Experience (MDCN 330 and 430)**

Within three months of entering medical school, students are introduced to clinical practice in family medicine. Three Wednesday afternoons are dedicated to learning how to write great SOAP notes in urban and rural settings. Students are delighted to get out into the community in ‘real’ time to get firsthand experiences and learn about the continuity of care. As class size changes, and seasoned preceptors move on, course chair Dr. Wendy Tink, and Department of Family Medicine Preceptor Recruiter, Dr. John Coppola, actively seek enthusiastic family physicians to share their craft with their potential new colleagues.

**Evidence Based Medicine (MDCN 440)**

Dr. Fariba Aghajafari has been part of the leadership team for this course for some time and recently took over the course chair position. This second year course includes an applied evidence based medicine component in Block 1 (August – October) and Block 2 (October – December) with clinical practice time. Sixteen family physicians participated this year.

Our retrospective review of students’ EBM skills, presented at the Society of Teachers of Family Medicine and Canadian Conference on Medical Education, demonstrated the need for continued effort in this area. In the coming year, we plan to teach students how EBM is evaluated using the FRESNO tool. While the strength of this rotation is clear, the gap in application to clinical practice remains.

**New for the coming year, the Department of Family Medicine will pilot a new family medicine research development program elective as a part of this course.** Academic family physicians Drs. Jim Dickinson and Kerry McBrien will be mentoring up to two students each on a focused family medicine research project over Blocks 1 and 2 (August through December). Students accepted into this program will walk away with a family medicine clinical research project proposal ready to set into motion. Stay
tuned for more innovations intended to build bridges between academic family medicine and community practice.

**Family Medicine Clerkship (MDCN 502)**

This year’s clerkship class ranked family medicine at the top! Clerks appreciated the sincere effort of community family physicians to increase clinical learning opportunities, answer questions about career opportunities in family medicine and create meaningful relationships with colleagues and patient during their 42 half day clinics. As before, the interactive clerkship placement map remains popular with tech-savvy students.

Clerkship Director, Dr. Martina Kelly has travelled widely across the province this year sustaining existing connections with our preceptors and creating linkages with potentially new faculty members. Each month Dr. Kelly travels to preceptor offices to gather feedback from our highly valued community preceptors and to share information about the program and its resources. Department-provided iPads with access to curated teaching materials are welcome additions to our teaching sites.

In January the Department launched the new Learning Environment survey for clerkship. This survey otherwise known as the Manchester Clinical Placement Index will allow us to gather important information from students about the quality of the learning environment provided to them during this part of their program. Information gathering will continue for approximately three years as part of an ongoing research project.

We are beginning to experience success with the “Morning Star” or patients as teachers program. In this pilot year, two students submitted nominations for patients who contributed significantly to their learning – see excerpt shown below. Recognizing a patient in the community as a teacher is an important transition medical students must make to be effective patient-centered learners in the future:

“...I feel privileged to have met (Patient X) and to have had the opportunity to provide care for her. In fact, I probably got more out of the interactions than she did...the most valuable learning was from what I learned beyond the medical aspects of her wellbeing. I identified her as a candidate for the Complex Care Plan, and...What I learned in this one hour will immensely impact how I practice medicine and view my patients in years to follow...I have become well aware of how root causes often resident in non-health sectors...It’s so easy for health professionals to ask patients to quit smoking, start exercising, eat smaller volumes, bring their A1Cs down to less than 7 etc. But we do not always inquire about potential barriers...life circumstances have caused her to become stuck, but I am hopeful that with this team approach effort along with her determination, we can help her life to the fullest once again.” *Ricky Agnihotri*
NEW FOR THE UPCOMING YEAR

DOPs Variation

This year we are re-introducing a modified version of the Direct Observation of Procedural Skills (DOPs) Program. New for this year, students will be asked to have two procedural skills (examples include inhaler technique and glucometer) signed off by a non-physician member of the healthcare team. In addition, groups of students will develop and test their own procedural skills checklists prepared before going into clinics to enhance self-directed learning skills. They will pick a skill, develop an evidence-based procedure, create an assessment form and field test the form before reporting back to the larger group following their clinical placement.

Patient Centered Home Teaching

Midway during clerkship, students return to the medical school for a full-day of teaching. New for this year, we are introducing a more discursive session on the Patient Centered Medical Home (PCMH). Dr. Charles Leduc and other speakers will address students on issues vital to thriving communities: access, economics and patient-centeredness.

CHALLENGES

- Physical space for students and clerks to see patients independently of other learners in family medicine clinics

  MDCN 330 and 430 provide excellent learning opportunities for UME learners in our family medicine clinics. University policies mean that preceptors must have faculty appointments in order to teach medical students, and many of our community faculty fall outside of this boundary. Each spring and fall coordinators and administrators scramble to find the approximately 164 clinical placements for our students. This remains a challenge.

- Recruitment of experienced academic physicians with undergraduate focus and experience

  Large medical school classes, combined with a university mandate to increase the number of family physicians from our university translate into increased numbers of family physician administrators required at the medical school. Recruiting family physicians to help assess clerkship projects is an ongoing issue.

- Competing demands on academic physician time including the necessity of scholarly output for academic physicians in administrator roles

  Physicians with small amounts of time dedicated to research continue to struggle to meet production targets in this area.

- Providing family medicine clinical research learning opportunities to University of Calgary medical students


Many students enter medical school with the intention of learning how to perform research in our specialty as part of the undergraduate learning. To date, very few of these requests have been accommodated. The new research development stream in MDCN 440 is intended to begin to address the shortfall.

- Attracting students to our specialty

The 2009 Task Force in Family Medicine targeted 50% of the graduating medical school class going into Family Medicine by 2013. Despite our concerted effort to increase numbers entering our field, work remains to be done.

**Future Directions**

The University of Calgary Medical School accreditation is scheduled to take place in 2016 with a mock accreditation scheduled for September 2015. Much administrative energy will be focused on preparing for these activities.

Ongoing initiatives including MedZero, MDCN 440 Family Medicine Research Development Program, the Morning Star Program and community engagement activities are part of our future.

**Quality Assurance, Quality Improvement & Innovation**

Feedback from our students and clerks, and new evidence from the literature continue to be the cornerstones of our continuous quality improvement activities. Four specific items highlighted here include:

1) **MedZero programming evolution to reflect the changing practice of family medicine in Southern Alberta**

2) **MDCN 440 Family Medicine Research Development Program to reflect the University’s ‘Eyes High’ research initiative**

3) **Morning Star Program highlights the movement of patients, particularly members of vulnerable populations, to center stage. This cultural shift, while in the infant stage, promises to increase community engagement.**

4) **Site visits and regular personal communication with our widely dispersed preceptors holds promise for us to be able to update regularly, resolve emergent issues early, and increase the quality of our relationships with those who teach for us.**
POSTGRADUATE MEDICAL EDUCATION

BACKGROUND

It has been an eventful year for the Postgraduate Program in Family Medicine. The Program graduated its first group of Triple C- Competency-based residents and underwent a program-wide accreditation conducted by the College of Family Physicians of Canada (CFPC). The Program continues to address challenges related to recent growth while enhancing its program offerings to ensure it continues to graduate highly skilled Family Physicians.

There were a few leadership transitions during 2014-2015. During 2013-2014, Dr. Lara Nixon took on the role of acting Postgraduate Director while Dr. Keith Wycliffe-Jones was on sabbatical. Upon Dr. Wycliffe-Jones’ return to this role, Dr. Nixon assumed the role of Enhanced Skills Program Director as of September 2014. Since then, she has taken a leading role in redeveloping the Enhanced Skills Program to better meet the needs of both residents and ultimately of the patients they will care for upon completion of their enhanced skills training. Dr. Wycliffe-Jones, who became Family Medicine Program Director in 2009 and then Post-Graduate Director in Family Medicine in 2011, will be stepping down from his role as of July 2015. The Department is currently seeking someone to take over this position.

The Postgraduate Program is comprised of three Programs: Urban, Rural, and Enhanced Skills.

Joining us in the Urban Program Curriculum “Domain Lead” roles are:

Dr. Lisa Coffey  Care of the Adult
Dr. Leah Genge  Vulnerable and Underserved Populations (VUPS)
Dr. Diana Grainger  Care of the Child
Dr. Turin Chowdhury  Research, Scholarship, QI and Patient Safety

In our Rural Program over the last year Dr. Rick Buck, Lethbridge Site Director, has been sharing the role of acting Rural Program Director with Dr. Bobbi-Jo Whitfield, Medicine Hat Site Director. As of April 1st 2015 Dr. Buck has taken on the position of Rural Program Director on a permanent basis and will be stepping down from his role as Lethbridge Site Director in May 2015.

Dr. Buck is a graduate of the first cohort of residents in the Rural Residency Program, bringing excellent experience and commitment to the Rural Program. Recruitment is underway to fill the soon to be vacant Lethbridge Site Director position while Dr. Bobbi-Jo Whitfield continues in her role as Site Director for Medicine Hat.

In the Enhanced Skills (ES) Program, new additions to the team include:

Dr. Heather Baxter  Maternal and Newborn Care Program Director
Dr. Victor Lun  Sport and Exercise Program Director (Interim)
Dr. Margriet Greidanus & Dr. Todd Peterson  CCFP-EM Program Director (co-directors)
The Urban Residency Program is managed in three geographic Divisions: Northeast, Northwest and South. Each Division is led by a Division Director and each has the support of a Division Program Coordinator. For the first time since the introduction of the new curriculum in the Urban Program in 2012, the program has a full complement of program leaders.

This year the Urban Program participated in two iterations of CaRMS. Across Canada over 100 Family Medicine positions were unfilled requiring the majority of the programs to offer a second iteration. During the first iteration the Department of Family Medicine had successfully filled all but five of its Canadian Medical Graduate (CMG) positions. The second iteration went well and the program is looking forward to welcoming its incoming residents for 2015-2016. 

As of March 31, 2015 the number of residents in the 2 year program totaled 157.

The recent accreditation visit was a great opportunity to show off the many strengths and innovations implemented by the Program in the move to the Triple-C Curriculum. Specific highlights of these strengths included:

- A very open program with outstanding preceptor-resident interactions which are collegial and supportive
- Nation-leading implementation of the Triple-C Curriculum
- An “amazing” new assessment program
- Strong leadership across all positions
- An enviable program evaluation model and
- An excellent service-to-learning ratio.

The Accreditation team identified some areas for continued focused attention as we launch into a formal curricular review this fall, including:

- Streamlining some of the Ambulatory Clinical Experiences (ACEs) to enhance learning and cut down on travel
- Ensuring access to video observation and call rooms to enhance learning opportunities
- Broadened demographic exposure and learner opportunities at some of our Home Clinics

The Urban Program continues to enhance its offerings while constantly evaluating, reviewing and improving existing elements of the curriculum. In 2014-2015, the program welcomed its first Integrated MSc Family Medicine resident into the program. This individual will complete the program attaining a specialty in Family Medicine in addition to a Master’s degree in Education.

Recognizing the specific health care needs of Vulnerable and Underserved Populations (VUPS) in Alberta and the requirements around teaching in this domain, the program also successfully filled the position of a VUPS Curriculum Domain Lead and continues to work on developing additional learning experiences for residents in this domain.
RURAL RESIDENCY PROGRAM
The Rural Stream of the Family Medicine program in Calgary has some exciting times coming up in the near future!

Accreditation has come and gone. The Rural Program is excited that the draft report from the CFPC accreditation team identified many strengths in the Rural Program including the strong leadership team, excellent supportive administrative staff, and acknowledgement of the important role that the training program has in accomplishing its social mandate of preparing rural family physicians for practice in Southern Alberta.

There are challenges in the next two years. With the Rural Program trying to transition to a curriculum that is “Triple-C” and competency-based, the program will be looking at changes in areas of assessment in addition to developing a more formalized competency based curriculum.

Great attendance was had this year at the faculty development focused event “Cabin Fever”. The initial reports reflect that the rural preceptors appreciated the opportunity for faculty development. In conjunction with the Department of Distributed Learning & Rural Initiatives (DLRI), the Rural Program will be looking at bringing the faculty development to the teachers at or closer to their home base in the near future.

The Rural Program is managed in two geographic sites: Medicine Hat and Lethbridge. Each site is led by a Site Director and each has the support of a Site Coordinator. Dr. Bobbi-Jo Whitfield is the Site Director for Medicine Hat and Dr. Rick Buck is the current Site Director for Lethbridge. He will be stepping down from this position in May 2015. A search is underway to replace him in this role.

ENHANCED SKILLS PROGRAM
The 2014-15 academic year has been a busy one with Dr. Lara Nixon stepping in as the new Enhanced Skills (ES) Director on September 1st, 2014 and everyone pulling together for the CFPC Accreditation survey team visit in February 2015. The surveyors were impressed by the leadership, curriculum and strong social mandate of many of the Enhanced Skills programs.

A new Enhanced Skills resident orientation was launched in July 2014 to welcome all ES residents and to help prepare them for the busy year ahead. Significant policy and procedure work has occurred this year to provide clarity for ES residents, Program Directors and administrative staff in key areas.
The conjoint oversight of the Palliative Medicine Program will continue until July 2016. Active discussions are underway to determine the future of this program, in hopes that a one year Enhanced Skills Palliative Medicine Program can continue to be offered to Family Medicine graduates, given the ongoing high demand for Palliative Care expertise in Alberta’s communities.

The Enhanced Skills Programs continue to grow in resident numbers. In 2013-2014, there were eleven Category 1 and seven Category 2 R3 residents. These numbers will increase to fourteen R3s in Category 1 Programs and seven in Category 2 in 2014-2015.

The Residency Program offers nine Enhanced Skills (or “R3”) Programs:

**Category 1**

1. Care of the Elderly
2. CCFP-Emergency Medicine
3. FP-Anaesthesia
4. Palliative Medicine (conjointly accredited by the CFPC & RCPSC)
5. Clinician Scholar Program

**Category 2**

1. Addiction Medicine
2. Global Health
3. Maternal and Newborn Care
4. Sport and Exercise Medicine
The Cumming School of Medicine Family Medicine Residency Program graduated its first class of “Triple C” competency-based residents in July 2014. Of the group of 113 residents, 78 were from the Urban Program, 14 from the Rural Program and 21 from the Enhanced Skills Program.

In graduating what is a record number of family physicians for the Calgary Family Medicine Residency Programs, the Department of Family Medicine continues to address the health care needs of Albertans and Canadians; this is supported by the results of the recently published “Graduate Survey” for graduates from the Calgary Family Medicine Residency Program between the years of 2006-2011; (Reference- Family Medicine Graduates Survey 2006-2011 Phase 1 Final Report. Torti, J., Szafran, O., Mackay, M., Anoyke, EA., Crutcher, RA.):

- 72% are practicing in Alberta
- 26% are practicing in communities with populations of less than 25,000
- 24% are providing intra-partum care
- 62% have active admitting privileges
PLAYING AN INTEGRAL ROLE IN ENSURING EVERY PATIENT HAS A FAMILY PHYSICIAN

Education and training play a key role in contributing to the achievement of the Medical Home Model’s goals. Residents are taught skills and given knowledge to help them better respond to patients’ concerns, preferences and experiences.

The program’s approach to teaching has culminated in the successful placement of Family Practitioners in communities. In 2014, 91.1% of Calgary Family Medicine residents successfully passed the spring sitting of the CCFP exam and 100% of residents successfully passed the CCFP examination in the fall.

Instructors with strong skillsets play an integral role in guiding future family medicine practitioners. The Urban Program continues to evaluate, recruit and develop over 70 community-based ambulatory clinical experiences (“ACE’s”) involving and engaging physician and non-physician health care professionals in resident teaching, sometimes for the very first time.

The recently completed accreditation survey identified the following strengths of the Urban, Rural and Enhanced Skills Residency Programs in Calgary:

- Committed strong teachers
- The high level of collegiality between teachers and residents
- The successful implementation of the Triple-C curriculum at the same time as a major expansion in residents numbers in the Urban Program The innovative introduction of Curriculum “Domain Leads” with the responsibility of developing and delivering the curriculum in the Urban Program around specific domains of care (care of the adult, care of the child etc.)
- A rural Residency Program that successfully trains residents for rural practice in Alberta
- The cutting-edge competency-based assessment program in the Urban Program
Dynamic, well-respected leadership at all levels, including in the enhanced skills programs

The strong social mandate in the enhanced skills programs, particularly in Emergency Medicine and Family Practice-Anesthesia

Increased connectivity of the Enhanced Skills Programs to the Department of Family Medicine

Currently the program is in the midst of a fairly dynamic review of its Global Health Enhanced Skills Program curriculum to define exactly what the expected competencies should be for graduates from this program in relation to meeting the health care needs of Albertans, particularly those of resource-poor immigrant, refugee and First Nations populations.
The Postgraduate Program is committed to training Family Physicians in providing care to vulnerable and underserved populations (VUPs) in Alberta. It is currently in the process of formalizing core competencies for this domain, in addition to creating academic and clinical teaching opportunities for all residents.

Currently, residents learn about the needs of unique patient populations largely through their Behavioural Medicine & Mental Health core rotation which includes clinical opportunities in addiction medicine (Renfrew Detox, 1835 Recovery House, Aventa Treatment Program, Opioid Dependency Program, Methadone Program at CUPS), Aboriginal Health (Adult Aboriginal Mental Health Services), low-income and homeless populations (CUPS Shared Care Mental Health), and patients living with FASD (John Howard Society and Med Gene).

As the VUPs competencies and curriculum are further developed, the goal is to increase clinical exposure in this domain to all residents. The program is exploring core learning opportunities to expand exposure in Aboriginal health, low-income & homeless populations and addiction medicine in addition to creating new experiences in refugee & immigrant health, prison medicine, LGBTQ health, and disability medicine.

In addition, residents have elective opportunities in the following areas:

- Aboriginal Health (Elbow River Healing Lodge, Siksika First Nation, Aboriginal Health Services)
- Addiction Medicine (Opioid Dependency Program, CUPS Methadone Program, Aventa, Claresholm Centre for Mental Health & Addictions, Addiction Services at FMC/RGH/PLC, Renfrew Detox Centre, Medigene Services)
- Low-income and Homeless Populations (CUPS Medical Clinic - which includes outreach clinics at the Mustard Seed, Alpha House, and the Calgary Drop-In Centre; The Alex; Pathways to Housing; The Alex Seniors Clinic, East Calgary Family Care Clinic)
- Immigrant and Refugee Health (Mosaic Refugee Health Clinic, NE Calgary Women’s Clinic, East Calgary Family Care Clinic)

Finally, the Department of Family Medicine offers R3 Enhanced Skills programs in Global Health (which encompasses domestic and international health) and Addiction Medicine. These programs enable residents to gain specialized knowledge in order to enhance their competency in providing care for these populations (e.g. rotations at specialized clinics such as TB services, Viral Hepatitis, Southern Alberta HIV clinic, Odyssey Travel and Tropical Medicine Clinic, rotations in Northern Canada and Low Risk Obstetrics in under-resourced communities). A recent survey of R3 graduates from the Global Health Program showed that all graduates now work clinically with marginalized populations in one form or another and actively act as mentors for learners interested in work in this area. The majority indicated that the skills earned in their training are fundamental to allowing them to now work with these patient populations.
CHALLENGES

The CFPC accreditation survey highlighted a number of challenges, most of which are already known to the programs, including:

- The need for a more formal program of evaluation in the Rural Program
- The lack of competency-based outcomes and assessment processes in the Rural Program
- Sub-optimal ambulatory clinical experiences in the Urban Program
- The lack of functioning video observation equipment in the teaching clinics
- Low patient volumes and restricted demographics in some of the academic teaching clinics in Calgary
- Insufficient full time academic physicians (FTA’s) and
- Administrative, curriculum and organizational issues mostly affecting the Category 2 Enhanced Skills programs

In addition, rapid growth has posed a challenge for the Program. The Urban Residency Program has maintained its expanded resident numbers for the third year in succession. While expansion has certainly contributed to the graduation of more family physicians for Alberta it has caused considerable strain on the Urban Program in the following areas:

- Capacity for quality learning experiences
- Preceptor-resident ratios
- Capacity for remediation of residents
- Reduction of potential transfers from other programs
The CFPC accreditation team has recommended that the two-year Family Medicine Program be accredited with an external review in two years and that the Enhanced Skills Program be accredited with an internal review in two years. The CFPC Accreditation Committee will make a final decision on these two recommendations and the recommendation that the jointly accredited Palliative Care Enhanced Skills program be accredited with a regular cycle review at their meeting in Ottawa in June 2015.

In the meantime, work is already ongoing in addressing the areas of concern identified by the CFPC survey team.

**Quality Assurance, Quality Improvement & Innovation**

- The Urban Residency Program has developed and implemented an innovative logic-model evaluation program that was commented on very positively by the CFPC survey team during the accreditation visit in February 2015.
- The evaluation program ensures that there is ongoing cyclical review of all learning experiences in the program and responses/changes that arise from these reviews occur in a planned and step-wise manner.
- The recent CFPC external review has provided the programs with an in-depth evaluation of the strengths, innovations and concerns identified by the survey team. The reports produced will serve as critically important guides to the ongoing quality improvement processes in each program over the next two-three years and beyond.
FUTURE DIRECTIONS & INITIATIVES

In addition to the ongoing program evaluation and quality improvement work in each of the programs, the following specific initiatives are either underway or about to commence:

- Rural Program curriculum review with planned implementation of changes in July 2016
- Review and implementation of competency-based assessment in the Rural Program 2015-2016
- Definition and development of Global Health Enhanced Skills curriculum
- Development of structured Maternity & Newborn Care Enhanced Skills Curriculum
- Major curriculum review of the Urban Residency Program in Fall 2015
- Continuing delivery of “Home Room Series” faculty development workshops for Urban Program Family Medicine Clinics
- Delivery of other specific faculty development events around teaching and assessment of FM residents similar to the evening workshop delivered to over 50 low-risk FM Maternity Care Physicians on assessment of the FM resident, in March 2015
- The development of better outcome measures as an additional element of program evaluation
- Ongoing exploration and consultation with other stakeholders in Calgary around access to educationally appropriate learning experiences for FM residents.
RESEARCH

NEW FACULTY AND STAFF

On July 1, 2014, the Department welcomed Dr. Turin Chowdhury as the new Scholarship Director. Dr. Chowdhury joined the Department of Family Medicine, coming from the Department of Community Health Sciences at the University of Calgary. He is a health services researcher with a medical degree, Ph.D. training in chronic disease epidemiology, and four years of postdoctoral research experience. Dr. Chowdhury replaced Dr. Maeve O’Beirne who began a one-year sabbatical on July 1, 2014.

We welcomed Tasnima Abedin, PhD candidate, to the Department in November 2014 in the role of biostatistician.

The Department filled the Scientific Advisor role with a new staff member, Gary Barron, PhD candidate. Gary began his new role in January, 2015 with the intent he would help faculty members in the areas of grant preparation, research methodology refinement, data collection, manuscript preparation, editing, and journal submission.

RESEARCH TOOLS SECURED FOR THE DEPARTMENT

- Fluid Surveys, an online surveying platform, was made available to the Department’s faculty and residents conducting survey data collection
- A separate Skype account was set up for scholarship meetings and to facilitate collaboration with researchers off-site
- Improvements were made to the Academic Department’s website with the research aspect of the website expanded considerably. The content that was added included additional resources for faculty, upcoming conferences and events, funding opportunities, updated faculty and staff profiles and photos, and links to abstracts and photos from past Research Days
- A Family Medicine Twitter account, @UCalgaryFamMed was created at the end of April 2015 in an effort to connect with our community, stakeholders, and physicians.
- Whiteboards with valuable information were installed in the Research Hub area at the Health Sciences Centre at Foothills Campus. Notices are posted about upcoming events, funding opportunities with deadlines and QR codes, and other valuable information. This information can also be found in the Department newsletters and on the website, but this whiteboard is up-to-the-minute current
- Faculty publications and presentations are now more easily referenced because the existing archive of faculty publications has been funneled into a central database that will make it much easier to cross reference and report accurately for our annual reports
- A Research Approval Pathways document was created in collaboration with the Scholarship Committee, and will serve to guide residents, community practitioners, and faculty through the route of Departmental approval for quality improvement and research activities prior to ethics submission
RESEARCH RESOURCES SECURED FOR THE DEPARTMENT

Family Medicine faculty located in the Health Sciences Centre now benefit from an analyst on site beginning November 2014. The analyst is skilled at extracting data from our billing records and can make physicians’ own clinical data available when considering 59 accessible variables.

RESIDENT SCHOLARSHIP

Review of Existing Materials

In 2014/15, the Scholarship Director and hub staff reviewed and refined processes related to scholarship for faculty and residents. Key updated documents include:

   a) Resident Quick Guide to Scholarly Work
   b) Resident Handbook for Scholarly Work
   c) Elective Research Request Requirements
   d) Process for Handling Resident Research Elective Requests
   e) FAQ’s for Residents Undertaking QI and Research Projects

Research Day 2015

Research Day was held March 19, 2015 with a fantastic turnout of residents and faculty, as well as high quality and thought-provoking presentations by Dr. Todd Anderson from the Libin Cardiovascular Institute and Dr. Jim Dickinson, our faculty presenter from the Department of Family Medicine. We had very positive reviews in the event evaluation and posted the resident abstracts and photos from the event on the Department website.

EVENTS TO ENGAGE POTENTIAL RESEARCHERS

We were active in participating in events to meet and engage faculty and community physicians interested in research. Through a number of events including Family Medicine Showcase, Fall Together, and the R3 enhanced skills wine and cheese, we extended our reach a little bit more and are looking forward to developing some research ideas that have been brought to us.

The Primary Care Research Group (PCRG) is being re-invigorated under the umbrella of the Institute of Public Health. The PCRG got its start several years ago under a previous Scholarship Director. Beginning in 2014/15, the Department will dedicate time and resources to make it relevant once again. It is anticipated that our commitment will be to provide speakers for the IPH speaker series, and we will focus our efforts on showcasing the Patient Centered Medical Home as well as supporting the primary care elements of the Calgary Inner City Research Group.

MEASUREMENT

While QI and evaluation continues to take place in the Academic Department, outside of our University of Calgary we are represented at several tables. Maeve O’Beirne, Allison Mirotchnik, Chris Diamant, Lucie Vlach, and Agnes Dallison represent the department at the Calgary Zone level on several committees of the Calgary Zone Primary Care Network Action Plan Initiative. These include sub-committees focused on EMR and IT needs, Medical Home, and the Evaluation Working Group.
In addition to the Calgary Zone level, we are represented provincially by Agnes Dallison at the Measurement and Evaluation Implementation Working Group (MEIWG) that is led by Lee Green, Chair of the Department of Family Medicine at the University of Alberta. This group is comprised of representatives from University of Calgary, University of Alberta, Alberta Health, the Alberta Medical Association, Health Quality Council of Alberta, and AHS. The intent of the MEIWG is to guide the implementation of primary care measures in the province. The Academic Department has an opportunity here to interface with the policy makers and to influence the direction of primary care measures in our own clinics and community. Towards the end of the 2014/15 academic year, work continues on refining the metrics for physicians and clinics in the measurement of primary care outcomes and service delivery. Ongoing consultations with PCN Executive Directors and physicians throughout the province have resulted in defining and operationalizing the measures. Currently toolkits to support the measurement work are being designed.

Agnes Dallison also represents the Department at the Measurement Capacity Initiative: The Next Generation (MCI), where we have been accepted into three streams of measurement. Through this work, the Academic Department is committed to contributing significantly to the provincial work being done collaboratively with PCNs, AHS, and community groups around primary care measurement. Ultimately, these initiatives will lead to meaningful primary care measures that are a cornerstone of the Patient Centered Medical Home.
Central Family Medicine Teaching Clinic

The Central Family Medicine Teaching Centre (CFMTC) had a focus for 2014-2015 to “lay the foundational blocks at the site level to prepare for advancing the Academic Patient-Centered Medical Home”. Key areas of focus for this fiscal period revolved around three main components:

- Reaching a baseline level of enhanced clinical resources to meet the needs of our patients and families healthcare needs
- Early review and initiation of Panel Management awareness and strategies to address the need to boost utilization of clinical services
- Facility enhancements and supply management improvements to provide a safer, more efficient practice environment

Though the clinic faced several challenges within the 2014-2015 fiscal year, all three of these key targets achieved high levels of outcome success, in addition to several other foundation building targets being accomplished as well.

The staffing model was re-designed to boost much needed clinically focused staffing capacity and capability and streamlined our clerical resources; allowing for enhanced direct service delivery during clinic visits and stakeholder satisfaction levels. Transition to a 2 LPN: 1 MOA per microsystem staffing model and redesign of routine clinical and clerical duties has allowed for an estimated 60% increase in clinical focused capacity without any impact to our routine clerical services.

Panel Management understanding and efforts towards improvement lead to the “re-attachment”, “clean-up”, and increased intake of new patients within our community. With continued physician workforce modifications, 3 exiting physician panels required having their panels “re-attached” with our clinic providers, which totaled a transition of almost 700 patients. Recent efforts near the end of the fiscal year saw the “clean-up” of more than 900 patients within one panel, which has allowed for a more accurate understanding of this physicians demand/capacity. As for new patient volumes to the clinic, we saw an increase of approximately 3200 new patients compared to same time from the previous fiscal (10500 in 2013-14 versus 13720 in 2014-15); a new patient growth of 30%.

In addition a Department level renovation to our site lead to several clinic focused environment improvements, including the move and modification of the clinic reception area, new administration spaces for site based clinic support team members, and significantly improved waiting space for our patients and families that raised the bar both in function and aesthetics. Lastly, a vast review of many supply chain processes and practices was conducted, from clerical focused supplies, to surgical instruments and medications. These thoughtful and systematic quality improvement projects to date have lead to greatly enhanced product management practices, user friendly spaces and tools, enhanced user satisfaction, and recognizable cost savings.
The CFMTC has made incredible strides in setting up a foundation for the future growth of our Academic Patient-Centered Medical Home. A common analogy on site is “we now have two oars in the water and we are heading towards our destination, and more oars keep getting added each day”.

**Accomplishments & Highlights**

**Staffing Workforce Re-Design**

Early part of 2014-15 fiscal year identified that our clinic had a need to review the staffing model of the time to address a gap in clinical service level capacity. In essence we had more resources dedicated to processing of clerical service requirements, but found ourselves often short of clinical capacity, especially in areas requiring the experience and scope of LPN’s. A systematic review was conducted to clearly identify the gap, and a business proposal was successfully supported to implement the new staffing model. In December 2014 the clinic moved to a 2 LPN: 1 MOA per microsystem model, in essence increasing the baseline LPN microsystem support by one LPN. Important to note this transition was made significantly easier due to attrition levels within the MOA float positions, and realignment of our LPN float position, thus funding levels to put in four new LPN positions came at a minimal cost.

Other successful outcomes achieved within the staffing transition were the detailed review of current and future state of routine clinical and clerical “daily duties”. Significant work with the staff and physicians lead to the development of new tools of communication to ensure any modifications to workflows within the new staffing model were clearly identified and streamlined the implementation of the new model. In fact, post implementation evaluation with staff and physicians revealed no need for process modification from initial implementation, and very positive feedback on the “roll out”. Lastly, though the key role of LPN Float funding was lost to main baseline staffing, the clinic culture to staffing assignment had been shift to one of all positions filled regardless of daily microsystem demand, to “staffing to daily needs”. Routinely, LPN staff is shifted based on the demand for the day, thus if a clinic does not have the clinical need for two LPN’s, staffing levels are shifted to “pull out” an
LPN to fill the previous scope of the LPN Float role (supporting QI initiatives, clinic staff resource, education, etc.).

In addition a Primary Care Nurse (RN) was hired December 2014 as a key member of the Clinical Leadership Support Team; a new recognized group within the clinic consisting of the Clinic Manager, Site Medical Lead, Primary Care Nurse, lead LPN, and Head Receptionist. The RN role has provides leadership support to the clinical team including the shared responsibility of overall day-to-day operations of the clinical area. Other key components for the role include design, development, implementation and evaluation of clinical education needs, as well as management/facilitation of various site level QI projects designed to advance the Patient Centered Medical Home initiative. The RN works closely with the clinical staff, physicians, Allied Health team members, and site leadership to ensure proper clinical workflows and processes are in place.
Advances in Panel Management

A great deal of focus in the fiscal year was around several challenges that were directly related to the need for improved Panel Management at the CFMTC. From lower than anticipated clinic utilization levels (median monthly estimated clinic appointment utilization July 2013 – June 2014 was 72.3%) and decreased satisfaction levels voiced by both medical learners, physicians, and staff. The need was clear we needed to significantly boost our Panel Management practices. Engagement with various external groups (CFPCN, AMA, AHS, other “like” service models within Canada and US, etc.) the clinic and DFM sought out examples and best practice within the arena of Panel Management. Significant efforts to find baseline understanding of our current demand/capacity “mismatch” were initiated, but quickly found routine, easily accessible and usable data was a challenge, and hoping to be addressed in the next fiscal.

Regardless of several barriers that were identified within the area of Panel Management, the clinic achieved some key “wins”. For example, the clinic had to address some physician workforce modifications in 2014-2015; the exit of three family physicians required the “re-attachment” of 700 patients from their current providers to new providers within the clinic, or support for them to find new medical homes in the community. This activity was completed well ahead of schedule based on CPSA recommendations, as patients were communicated with individually by letter and phone to ensure their knowledge of the modifications, and their desire to retain the clinic as their medical home.

A second implementation within Panel Management was enhanced panel identification efforts. Key site staff and leadership members attended training sessions around advancing panel management, later in the 2014-15 fiscal year, and have continued into the next. With this has come the design and implementation of various “panel re-attachment and clean-up” workflows for various workforce situations. From new physician providers coming to the clinic, to exiting providers, and simply “cleaning” the panels of our current medical provider team, all efforts are underway to ensure we more accurately know which patients view us as their primary health care provider service.

For example, one physician panel, which had been the collection of a few recent panels in the last few years via different physicians whom had left the clinic, was in dire need of “clean-up”. First round efforts, looking at those patients whom had not attended the clinic for a visit in greater than three years, lead to the confirmation of 956 patients that no longer called CFMTC their medical home (had other provider, no longer interested, other), three patients requested to remain within the panel, and 23 patients we could not reach with the current demographic information. This one example showed just how important routine panel identification practices are key to effective management of the Patient Medical Home.
Early specific successes includes the successful start of “re-attaching” another round of exiting physicians as of June 30, 2015; a total number of more than 1200 patients. New family physicians to the clinic in this reported fiscal has led to the smooth intake of a reported increase of 3300 patients, whether the MD had a pre-existing panel that came with them, or has been grown from the demand within the community around the clinic. In fact, when comparing last fiscal reported total active patients identified within the clinic (10500) to one year later (13720) the clinic has experienced and overall net gain of new patient volume between these two fiscals of more than 30%.

Facility Enhancements and Supply Management Improvements

Actualization of a department/clinic project on the 8th floor of the SMCHC lead to the completion of a renovation which had several clinic focused environment improvements. Previous design limited effective patient/family queuing capabilities for the reception area as it was very close to the elevator corridor, a very busy “high flow” entry/exit point for our clinic and the entire floor. By moving the reception area to a more efficient and effective floor location we have achieved better flow of patients and family members, providers, and other individuals whom come to the eighth floor. Staff report a more functional reception space, increased privacy for patient interactions, and better set-up for managing the patient “line-up”.

With the move of the reception area, the new “primary waiting area” is more functional and aesthetically pleasing, allowing for caregivers for patients a more comfortable place to relax will the patient is being cared for in the microsystem. Prior to the renovation it was very rare to see anyone using our 2 previous waiting spaces, now it is common to see several individuals throughout the day, reviewing boosted clinic communications, and taking in the incredible via of the Central Memorial Park.

Reduction of the amount of square footage used for previously underutilized waiting areas (as each microsystem also has small waiting rooms) was able to be re-used to create a new five desk enclosed administrative area focused on the work stations for clinic focused scheduling, admin, and documentation management specialist roles. All of these roles provide key support to CFMTC clinic operations, and having them more “entrusted” within the clinic on the floor has allowed for enhanced workflows, boosted communication, and reduced siloization of these roles from routine clinical operations.

As well, a vast review of many supply chain processes and practices was conducted, from clerical focused supplies, to surgical instruments and medications. Several key projects which have led to significant improvements include:
• The Procedure Rooms “Makeover” incorporating:
  • All room storage elements reorganized, labelled and standardized, including min-max stocking level identification
  • Systematic review of current surgical supplies leading to removal of unused tools, boosted supply levels where required, and improved labeling practices for each widget stocked
  • Modifications to standardize stocked suture supplies
  • Introduction of Gyne Carts to each microsystem
  • Review of routine gyn procedure focused supply needs, all to be housed in portable carts for use in any appropriate patient space
  • Continuation of same standardized labelling practices within the clinic, including min-max stocking level identification
  • 1 cart per microsystem (total of 4)
  • Module Carts Renovations
    • All Module Carts were re-organized, labelled & standardized, including min-max stocking level identification
  • Pertussis Kit Expansion – increased to 2 kits within the clinic
  • Medication Room Organization Project
    • all room storage elements reorganized, labelled and standardized, including min-max stocking level identification
    • reduction and update of current / relevant poster materials
    • boosted supply of nourishment products for patient needs clinically
  • Clean Utility Room Fall Cleaning Project
    • Review and re-organization of all stocked “clean” supplies for the clinic
    • Enhanced relationships and service agreements with both vendor groups and AHS supply management group
    • Streamlined ordering practices
    • Collection of baseline expired product levels, and collection receptacles for future evaluation of expired product waste within the entire clinic (medications, supplies, etc.)

Overall, these efforts taken have led to significant quality improvement outcomes, from improved safety and access by ensuring products are not expired, in the room when needed, well labeled products for reduced supply use error, and providers have the “right tool for the job”. Efficiency increases, with less walking time to get missing products, or scrambling to find what you are seeking. As well as enhanced cost effectiveness, in streamlining provider time, resources for stocking, and wasted products. Though our hope is to have more future resources for evaluation measurement to show data focused outcome measures, some early quality assurance efforts are hoping to indicate significant cost savings for next fiscal.
CHALLENGES

Several barriers were identified within the fiscal year which impacted the clinics ability to achieve potentially higher levels of patient-centered medical home gains. One major challenge was a high level of staff and provider turn over. Efforts to realign the physician workforce caused increased workload and anticipated delays to re-organize and align patient panels and acceptable visit volumes. We also experienced a nine month gap in filling a critical role; the Site Medical Lead. Despite interim coverage support, this had a significant impact in aiding the progress of key clinical improvement work and routine operations, so we were very pleased to have this position filled in October 2014.

High volumes of staff turnover also plagued the clinic, especially for a three month period in Q3. Ten staff were hired within this time frame, either due to attrition, long term leaves of absence, or the reorganization of our staffing model. We are pleased to report being at above 97% baseline staffing since Q4 and into the new fiscal year.

Of all staffing transitions that occurred by far the biggest impact was to our reception team. This discipline group way up to 50% reduced from its baseline levels for a couple months, and with onboarding and training up to new staffing levels, this gap did have an impact on our ability to sustain routine service to the same high standards, but most of all enabled us to increase the new patient volumes we so desperately needed to achieve to reach our utilization targets, clean our panels, etc. But thanks to the incredible efforts of all staff and providers, but especially the reception team, within the clinic we were able to “ride out” these struggles, and were able to achieve still very recognizable improvements in our patient volumes, visit volumes, and continuation of high standards of reception services to our patients and families.

![Volume of Visits at Central Family Medicine Teaching Centre](image)

Other challenges the CFMTC faced over the last year identified:

- Capacity and capability to support an ever growing level of IT demand. From training to metric production, this is a challenge that continues to grow at the site level. However, efforts in the last part of the fiscal have been moving this challenge in the right direction with boosted Department Level IT support resourcing, expanded site level Super User support (four staff trained or in process) and boosted enhancements for generalized EMR training and work flow documentation have begun.
• Transitioning of policy and guidelines that align with AHS, especially those related to clinical practices
• Resource support to address large volume of QI projects and initiatives, and it can be difficult to support this improvement work “off the side of the desk” when many roles are dedicated to routine clinical services. Despite this gap, creative resourcing (scope expansion of various roles, staffing based on visit demand, etc.) have allowed for reaching many successful QI outcomes as previously mentioned (especially since reaching baseline staffing levels)
• Clinical space limitations – with the growth of staffing levels, and expansions of Allied Health services creative solutions have been implemented to maximize room utilization. But any further growth will certainly be limited by our physical space in the near future

QUALITY ASSURANCE, QUALITY IMPROVEMENT & INNOVATION

Though formally the sites Clinic Improvement Team (CIT) will be launched May 19, 2015, all pre-work to determine the site level starting point for a Quality Management Framework (QMF) went into full stride in Q4. In tandem with progress at the department level to determine the starting direction for the advancement of the Patient Centered Medical Home, the Site has been confirmed to pilot the AHS Improvement Way (AIW) as “an approach to informed problem solving” and the primary framework to work through many of the QI initiatives into the next fiscal. Early efforts to glean out key performance indicators relevant to the site level for enhanced operational service and outcome monitoring has begun, and foundations are being laid, both structurally and culturally within the site for the up and coming events planned for the next fiscal. In general the site is excited to not only have a clear vision for the future of an Advanced Academic Patient-Centered Medical Home, but also the early bricks being laid for how we will approach this vast and promising model of care.

FUTURE DIRECTIONS

Boosted Health Management Program

In collaboration with the two other sites we hope to work together to:

• Development of standing orders (standard care plans) for the health management nurses to adjust treatment within specific parameters, allowing them to practice to their full scope
• Reach new levels of Interdisciplinary care by building stronger workflows and collaboration of allied services, though predominantly provided by external parties (multiple PCN groups, outside AHS service groups, etc.) finding new ways to connect the allied services directly to the clinical providers and staff more routinely thus reducing “transition of care points”, more real time information transfer
• Potential launch of a Patient Care Coordinator role
• More data driven decision making and collaboration with our partners in care, such as the PCN’s and other provider groups within the community
Panel Management

- Completion of the site level panel identification efforts including all individual provider panels being “cleaned” to ensure all patients identified in our systems see themselves being patients within our clinics medical home, as well as each patient “Profile Tab” being up to date. We will also launch a robust strategy to maintain regular panel cleaning activities so as to not slip back to our previous pre-cleaning baseline state
- Initiation of elements of ASaP, for enhanced screening practices
- Clearly identify and implement a site level approach to panel size determination and management process to ensure we are routinely ensuring we are optimizing our clinical resources and significantly improving our “supply / demand mismatch”

Formal Initiation of a Site Level QMF

- Launch of CFMTC – CIT on May 19, 2015
- Commence next level of AIW training with CIT members as a start (Core Training Level), to include belting
- Set foundational elements for CIT operations including Terms of Reference, implementation of an “Opportunity Intake, Tracking, and Prioritization” system
- Build stakeholder relationships, and workflows for effective QI projects, and evaluation/sustainment strategies
- Further define linkages to other system levels within the broader QMF both at a more microsystem level as well as Departmental / Organizational levels
South Health Campus Family Medicine Teaching Clinic

The South Health Campus (SHC) Family Medicine Teaching Clinic has continued to develop a medical home in the past 2014-2015 year while keeping the SHC pillars of Patient and Family Centred Care, Collaboration, Innovation, and Wellness within focus. Patient numbers are calculated monthly and show that the Clinic continues to provide Patients and Families within the community with an opportunity to have a personal family physician. Residents have patient panels and together with the clinic booking guidelines continuity of care is provided facilitating care that is responsive to patient and family beliefs, values, and experience.

Goal 1: Patient Centred Care

The Patient and Citizen Innovation Council (PCIC) continue to meet every three months (four times per year). The council consists of five patient/citizen advisors, the site medical lead and manager. The terms of reference have been developed and approved by the council. Patient/citizen advisors attend the monthly physician, staff and Quality Improvement working group clinic meetings. Their attendance and contribution at these meetings is valued and integral to the changes and steps being taken towards the development of the medical home.
One of the initiatives set for 2104 was to evaluate the clinic’s patient centred care - customer service delivery model. A patient satisfaction survey has been developed by a member of the patient advisory council. Input from the South Health Campus Citizen Advisory Team (CAT) and the PCIC council has helped develop and revise the tool. The survey will be delivered by members of the PCIC to the patients of the clinic in the spring of 2015. Patients are asked to draw on their experiences (previous visits) in the clinic when answering the questions. The survey results will help engage community members in an effort to improve the quality of the care experiences in the clinic. The feedback will help develop a medical home where patients and families receive primary care which is accessible, continuous, comprehensive, family-centred, coordinated, compassionate, and culturally effective.

Two PCIC patient/citizen advisors presented at the resident orientation in July 2014. It was well received providing the new residents with both a patient and community perspective on health care relative to the patient experience. They are scheduled to attend the resident orientation again in 2015. The committee also was accepted for a poster presentation at the Accelerating Primary Care Conference in Edmonton on December 2014. The title of the poster was “Is a Patient/Citizen Council Right for Your Neighbourhood? A step-by-step approach on how the SHC Family Medicine Clinic implemented a Patient/Citizen Council.”

**GOAL 2: PERSONAL FAMILY PHYSICIAN**

In the document, *Guide to Panel Identification for Alberta Primary Care* dated April 2014, the College of Family Physicians of Canada (CFPC) identified that focusing on strengthening the physician-patient relationship (relational continuity) was the foundation for quality care.

Relational continuity in conjunction with optimized use of multidisciplinary teams helps to support excellence in the delivery of care to patients. It also supports and addresses three of the goals and objectives of the Patient’s Medical Home:

- **Goal 2:** “A Patient’s Medical Home will ensure that every patient has a personal family physician who will be the most responsible provider (MRP) of his or her medical care.”
- **Goal 3:** “A patient’s Medical Home will offer its patients a broad scope of services carried out by teams or networks of providers, including each patient’s personal family physician working together with peer physicians, nurses, and others.”
- **Goal 6:** “A Patients Medical Home will provide continuity of care, relationships, and information for its patients.”

Relational continuity, or an ongoing relationship between a physician and patient, requires a panel identification process. In 2013, *Academic Family Medicine at the South Health Campus enrolled in the Alberta Screening and Prevention Initiative (ASaP)*. The objective of the Alberta Screening and Prevention initiative is to increase the percentage of patients that are screened by their primary care
providers, with the emphasis on targeting patients that do not present for screening. In order to implement the ASaP initiative effectively, we needed to know who our patients were and how screening was being offered to them already and what our current use of the EMR was.

The first step our clinic needed to take was to identify and assess our current processes surrounding patient panels, how our clinic panels were managed and what roles our team members played in this process. Throughout this past year, we have worked to identify our current processes around panel management, areas of inconsistencies, ways to standardized electronic medical record (EMR) use to assist with panel identification and we have worked to identify what team members are involved in the day to day management of our clinic panels. Team members including management, RN’s and clerks have participated in formal courses on Panel Management offered by Towards Optimized Practice (TOP) and have in turn shared with colleagues the knowledge gained to help facilitate this process.

We worked on, and continue to refine our processes, through both formal and informal meetings, and discussions as part of our commitment to continuous quality improvement. We have and continue to work on ensuring that our patients have and are aware of who their primary care physicians and secondary care physicians (residents) are. Patient demographics are continuously updated to ensure they are accurate. We strive to ensure that we are providing optimal continuity of care ensuring that patients are booked with their primary and /or secondary care providers (residents) whenever possible, employing our clinic booking process to guide us. We have worked to ensure our documentation in the EMR is entered in a standardized way and that patient status is defined and utilized to differentiate our Active patients in the EMR from those who are no longer attending the clinic. We have also developed and are refining a process by which we will have ongoing, routine panel reviews to ensure accuracy and continuously updated panel lists for each physician in our clinic. Our process includes the participation of most of our multidisciplinary team here at the SHC, including management, our physicians, residents, nurses, both RN’s and LPN’s, clerks and reception clerks and our patients.
Through this process, we focused on being able to meet Goals 2, 3, and 6 of the Patient’s Medical Home as listed above, and we have also worked to meet Goal 7, by improving and implementing a standardized process for maintaining our Electronic Medical Records (EMR) as well as Goal 9, in our commitment to continuous quality improvement.

Through this process, as a clinic we have:

- Improved and standardized our EMR use
- Continued our commitment to provide continuity of care to our patients
- Worked with our patients to assist them with establishing relationships and accountability with their primary care physicians/secondary care physicians (residents)
- We are in a better position to implement our next phase of ASaP which is to meet the objective of providing Preventative Health Screening to patient’s who don’t present to our clinic for routine screening. Through panel management, we are able to identify those patients that do not present to the clinic routinely and through chart reviews, conducted by nursing in collaboration with physicians, we can identify and offer outstanding screening to these patients through opportunistic and outreach approaches.
- We continue to strive to provide our patients with access to same day care. One of our current Quality Improvement projects is measuring patient satisfaction through the use of a Patient Access Tracking Form. Reception tracks appointment requests to assess overall patient satisfaction with our ability to meet their needs in regards to scheduling appointments with their primary / secondary providers in the “patients” requested time frame.
Our panel management processes have allowed us to continue to open our doors to new patients. Through active panel management, we ensure that we can better plan the distribution of patients amongst our various physicians and teams and readily identify capacity.

Through panel management, we have engaged our entire multidisciplinary team in the coordination of planning and supporting care for our patients.

Moving forward, we will continue to refine our current process and progress with a regular and ongoing process to review each physicians panel a minimum of once a year working to identify that the needs of our ongoing regular patients are met in regards to continuity, screening and ongoing medical care. With our process we will identify and flag patients that have not been seen in clinic within the time frame identified in our process protocol and offer them appropriate preventative screening at appropriate intervals and we will identify those patients no longer receiving care at the clinic, deceased and patients who have moved or otherwise transferred their care.

**Goal 3: Team Based Care**

**ASaP Improvement Team**

How we arrived where we are today:

- In 2013, Academic Family Medicine at the South Health Campus enrolled in the Alberta Screening and Prevention Initiative (ASaP).
- Towards Optimized Practice (TOP) reviewed data and found that physicians were doing an outstanding job of screening individual patient’s during focused screening visits such as periodic health exams (PHE), but the data found that approximately 1/3 of patients do not self-present to their physicians and therefore they do not receive the same level of screening.
- The objective of the Alberta Screening and Prevention initiative is to increase the percentage of patients that are screened by their primary care providers, with the emphasis on targeting patient’s that do not present for screening.
- The ASaP initiative is focused on supporting primary care providers and their teams to provide patient’s with screening and prevention bundles.

Benefits that we have discovered during this process:

- Cleaner patient panels
- Increased awareness of continuity of care, creating awareness around how we schedule our patients to ensure that we offer our patients continuity where we are able to. Our patients are more readily able to identify and establish rapport with their primary care providers which helps facilitate screening efforts.
- Heightened awareness of screening overall by all staff and clinicians
- Increased standardization of how data is entered into the EMR by staff and clinicians
• The creation of a new document in the Profile page of the EMR that summarizes, at a glance, what screening has been done.
• Participation has allowed us to operationalize the Goals tab in the EMR. The goals tab provides staff and clinicians with a summary of screening pertinent to any given patient. At a glance we can see what screening is up to date and what screening is outdated or required.
• Overall increased familiarity of the Med Access EMR and functions such as Clinical Decision Support (CDS) triggers that can assist us in providing better care to our patients.
• Increased efforts to outreach to patients that are overdue for screening and increased offers of screening to patient’s opportunistically.
• Enhanced teamwork, the prescreening completed by nursing staff prior to the patient visit has enhanced patient care and decreased the amount of time physicians spend online searching for patient labs and diagnostic test results pertinent to screening. This is gathered and attached to patient charts prior to visits and provides clinicians with a more complete picture of their patient’s health histories and screening thereby enhancing use of the appointment time spent with the patient.
• Increased awareness, education and dialogue with our patient’s about the importance of screening and early detection as well as the importance of continuity of care, patient’s getting to know their physicians and physicians knowing their patients more thoroughly.

Moving forward:
• We continue to face some EMR challenges in working with goals and we continue to evaluate the ASaP Questionnaire created in the Profile tab to ensure that it is functional and that it is meeting the needs of the physicians. With the assistance of Chris Diamant, Carol Hort, and Med Access, we continue to make changes and evolve as required and where we identify limitations of the EMR we work to resolve the limitations if possible or develop workflow processes that best support our screening efforts.
• We continue to educate staff and clinicians on EMR usage, including standardizing where and how we enter screening data, and the importance and benefits of an accurate Goals tab.
• We are beginning to move our focus in the direction of Panel Management so we can better identify patient’s that do not self-present for PHE’s. We will be offering them opportunities to come in for screening. We are also trying to identify what the barriers to preventive care/health screening are for these patients. We would also like to ensure that our panel sizes accurately reflect the patients who are active in our clinic.
• We also plan to begin moving in the direction of opportunistic screening of patients to capture patients that frequently visit the clinic for other concerns, but are outdated in their screening.
• We are also planning to ensure continued engagement of our staff and clinicians. By continuing to emphasize the importance of screening and early detection and intervention, as well as, prevention using continuing education initiatives such as an ASaP improvement board, and ongoing lunch and learn sessions that will involve our learners and residents.
Accu-Med Team
The past year has been one where we have been developing a collaborative care model. In the
development and implementation of the model we applied the concept of collaborative practice literally
and made the program truly multi-disciplinary and inter-disciplinary. Within the collaborative care
model we went one step further and involved the family of the patient as well. The patient in all
encounters must be treated as the head of the collaborative care team involved when providing care.
The healthcare professionals involved in providing care can only provide the care if the patient is seen
as, and treated as the central part of the team. In developing the relationship with the patient we also
develop a relationship with the family. Family is defined as any significant person who is involved in
providing care to the patient. This professional relationship may involve full disclosure with the family or
partial disclosure depending on the situation between the patient and the family.

In developing the Accu-Med program we have nursing staff, residents, physicians, family and community
pharmacists all involved in maintaining a current and up to date EMR profile of medications for the
patient. The collaborative practice model works well when we have all the team involved since we are
then able to better document meaningful and relevant information. We started off with the premise
that Accu-Med within the clinic was a triad partnership: the patient/families, the care team and the
community pharmacist, thus collaborative practice. This has borne out well over the past year as we
have developed relationships with the community pharmacies and they now have a contact to the clinic
to convey relevant information.

The inclusion of all medications, including over the counter (OTC) and naturopathic medications is also
important since during an Accu-Med intervention we will also perform an interaction check on all
medications; any interactions are also documented in the EMR. The role of the interaction check is to
ensure patient safety and to exhibit to the patient that we take all of the medications they ingest as
being important parts of their therapy. In situations where we do uncover interactions we will plan an
education session with the patient and the family/caregivers to ensure they understand the risks
involved in certain combinations.

During the time of assessment we not only look at medication interactions but we also look at
medications that may be affected by changes in lifestyle. An example of this is a patient being treated
for migraine prophylaxis with a beta blocker who suddenly wants to start an aggressive exercise
program; the beta blocker may limit the ability of the individual to exercise and at that point we would
have to work with the patient to find an alternate treatment agent for the migraine prophylaxis. During
this interview we will also assess the patient’s ability to pay for the therapy prescribed since the best
therapy cannot financially fit into the budget so is not going to be used and alternate treatments will
have to be accessed. In cases of consultant changes we may find that the patient will be provided with
samples of “new and improved” medications that the patient’s medical coverage will not pay for; at this
point we will assess if the medication needs prior authorization or if it is not on the insurance formulary.
If it is not on the formulary we will not include it in the EMR and will resort to agents that are covered
for patients with limited means. Working in the team we have developed a way to document all of this
information into a chart note and also document that the Accu-Med intervention has been completed.
with references and other chart notes that are pertinent to care. With all of this information
documented better decisions on care and treatments can be made in a timely and effective manner and
at the same time ensure patient safety. This has enhanced the accuracy of the EMR record and has
assisted in developing the needed relationships within the community; this relationship has expanded to
more than just the Accu-Med initiative.

The main goal for Accu-Med in the next year is to quantify the accuracy of our EMR records to
demonstrate that the approach we have taken has actually improved accuracy and by extension it will
have increased the safety threshold for the patient as well.

A poster presentation on the Ace-Med process developed at SHC was accepted at the Accelerating
Primary Care Conference in Edmonton in November 2014. ix

GOAL 4: TIMELY ACCESS; COORDINATION OF CARE

The clinic implemented a same-day scheduling system,
known as advanced access when it opened in August
2012. It was a system that was relatively easy to
implement given that the clinic was new, and the patient
numbers were low. We had less demand than supply
(physician capacity). Ongoing monitoring and ensuring
there is a balance of supply and demand is essential for
same-day booking and to ensure a backlog of patients
waiting for appointments does not develop. The Quality
Improvement working group at SHC meets monthly and has developed a process of measuring access.
Rather than look at the third next available appointment reception staff are tallying whether patients
are able to secure an appointment on the day and with the provider they have requested. Appointment
lengths and types remain simplified with short (15 minute) and long (30 minute). There are no
“reserved” or emergency appointments keeping with the philosophy of “doing today’s work today” and
ensuring that there is enough capacity to meet each day’s patient demand.

Advanced access can improve patient wait times and reduce no show rates. High no-show rates have
been shown to be associated with longer intervals between visits and confusion regarding the reason for
follow-up visits. The clinic no show rate has been shown to be 6 to 7%. A small study aimed at
determining whether reminder calls would reduce the no show rate was conducted. The no show rate
remained the same whether an appointment reminder call was placed or not. Appointment reminder
calls have now been discontinued except for appointments with our shared mental health providers due
to the patient wait time. The reasons for no show appointments have been tracked. There is a large
category of “unknown reasons for no show”. The QI working group is developing a patient survey to see
if additional data can be obtained that would help the clinic address the no show rate and/or if
interventions could be put in place to help further reduce the clinic rate.

An increase in pharmacy faxed prescription renewal requests has been noted by the clinic. Patients are
advised that they need to see their physician prior to a prescription renewal and to approach their
pharmacist for a short renewal so there is no disruption in their medication regime. Data is being collected to determine the number of faxed prescription renewals received by the clinic on a daily basis and the reasons for the prescription renewal request. Strategies regarding prescribing practices will be reviewed to determine whether the prescription duration should be used to “proactively” trigger patient follow-up appointments.

**Goal 5: Comprehensive Care**

When working with our patients who suffer from chronic complex diseases, collaboration and coordination of care has also been a benefit to the patient. The involvement of our nursing staff, social worker as well as dietician has improved the health outcomes for our patients. Using the collaborative care approach allows the patient to have greater input into the care plans and what they feel is appropriate to them in their situation. This approach has been a success for many of our diabetic patients who now feel that they have a group of people within the same clinic working with them to get to a goal. Input on setting and ownership of the goal by the whole team can then translate into success for the patient in the long term.

Complex patient care plans are routinely developed by the chronic disease management nurse according to the patient need. The methodology for health behavior change is utilized where patients together with their health provider and allied team member/members set their health and wellness goals and the strategies to achieve their goals. High risk patients are identified and shared visits with the physician/resident and allied health team member are planned together and in advance of a follow-up visit. This approach helps ensure that individual level data is available at the time of the patient visit. Case review meetings are scheduled when indicated to ensure that all outstanding patient needs are addressed at each patient encounter.

Quote from an allied health team member: “As a social worker and allied health professional, working collaboratively with family medicine physicians benefits the people we serve. It results in a comprehensive assessment of patient and family need and acts a catalyst to further support the patient and their family in their community, in turn, contributing to better health outcomes. Working collaboratively can not only limit barriers to care, it has the ability to minimize disruption to a patient and their family’s life by providing care in time and place as they face their health challenges”.

147
Goal 6: Continuity of Care, Relationships and Information

Appointment systems are flexible and are designed around meeting the patient needs in a timely manner. Application of the Lean approach has identified some “waste” in the management of telephone calls and inquiries. A systemized approach on how and where to direct phone calls has been developed so that customer
service is handled in an efficient and directed way.

Residents are assigned patient panels and they are encouraged to add new patients to their panels throughout their two years at SHC. Continuity of patient care is addressed by using clinic scheduling guidelines and practices. The second year residents work off their own independent schedule in the EMR allowing them to independently manage their time and provide care to their patients while under the mentorship and guidance of their preceptor.

Collaboration with other departments in the SHC such as the Nurse Practitioner - Urology and the Wellness Centre (YMCA) has helped incorporate and plan the patients care. The clinic pharmacist will be teaching a session on Herbal Medication and what you need to know to our patients and to the community. It will be held in the Wellness Centre at SHC. Feedback will be obtained from patients and families about the education session and will be used to plan other sessions.

Advanced care planning is part of the patient care journey and teaching and resources are available to patients and families.

**Goal 7: Electronic Medical Records**

The clinic follows the standards for recording and following patient care as established and set by the EMR steering committee. ASaP has developed a process for activating patient screening goals (EMR) and standards for setting the EMR goals up along with developing individualized patient screening manoeuver goals.

Room finding and location has been identified as an issue for physicians and residents. A pilot project that will utilize the Med Access room locator function is to be trialed with the modules to determine if an electronic solution will assist.

Data is gathered monthly on patient numbers, physician/resident panel sizes that assist in planning and taking new patients.

Patients have access to an allied health team member and they are available through a self-referral if needed or requested. The EMR consultation tools and referral processes are followed so that there is appropriate and accurate recording that documents to patient care journey.
GOAL 8: EDUCATION, TRAINING & RESEARCH

Nursing students and pharmacy students complete practicums in the clinic.

Resident resource room with medical text books and other training resources are located in the clinic.

Collaborative practice in learning has also been instituted in our twice weekly learning sessions. In the past we have had only physicians and residents do most of the sessions, we have had a number of different disciplines do presentations over the past year and these have been good bridge builders to others as well. We had a recent presentation by the YMCA at SHC that explained the many programs and initiatives that are occurring in that department within the facility. With this information everyone in the clinic was at a greater advantage on what to say and provide patient appropriate and accurate information when they want to pursue a more healthy and active lifestyle. Collaborative care not only benefits the patient that is receiving care but also benefits the caregivers as well since they then realize that we may say that we are all working to the same goal for the patient but when this is acted out in actions one becomes aware that this is a real possibility and is a goal that we must strive for and a Pillar of our facility. To quote a short bit of lyric;

“No man is an island, we can be found
No man is an island, let your guard down
You don't have to fight me, I am for you
We're not meant to live this life alone”

We would like to change this a bit and say we are not meant to give care alone and working in the collaborative practice model we are never alone. This model is taught and practiced within our SHC team.

GOAL 9: EVALUATION

Staff is learning about the Plan-Do-Study-Act (PDSA) process and how to write a PDSA, present an issue and evaluate outcome.

Clinic data on:
- Physician panel numbers
- Resident panel numbers
- Average number of patient visits for physicians
- Average number of patient visits for residents
- No show rate
- Patient access
- ASaP chart audit
  - Is collected monthly and posted in the clinic.

The ASaP Improvement Board is used to post a monthly screening manoeuver and clinic statistics based on patient chart audit.

### ASaP Screening for January 2015: Percentage of eligible patients with CV Risk Calculations noted on file

- 77.60%: Percentage of Patients with No CV Risk Calculations on file
- 22.44%: Percentage of Patients with CV Risk Calculations on file or noted to be "High Risk"

### CV Risk Assessments Completed in PHE Visits at SHC Clinic From January 1 - 30, 2015

- Total Number of Patients attending PHE Appointments from January 01 - 30, 2015 Eligible for CV Risk Assessment
- Females
**Goal 10: Systems Supports**

Standard clinic practices and processes have been developed to support the SHC’s journey towards the development of a medical home.
Sunridge currently has 16 teaching physicians (8 FTE) and 21 staff (including three casuals) who managed 5935 patients and approximately 24000 patient visits in 2014. More than 125 learners, including residents, externs, clinical clerks, medical students and various allied health students were both taught and supported in their research activities during the year.

In an effort to improve our ongoing patient care, teaching and research responsibilities, several initiatives were started or continued. Two of the initiatives started or undergoing significant change this year were the Health Management Program and our resident academic teaching program. The Health Management Program, encompassing six pillars of the Patient Centred Medical Home, was developed with the goal to provide high quality, patient-centred care while reducing visits to attending physicians, therefore allowing for increasing panel size and more efficient patient access. The resident academic teaching program was modified, increasing the frequency of the rounds and presenters, leading to more diversity of topics, record attendance, increased discussions and knowledge acquisition and collaboration between all members of the clinical team at Sunridge.

The most significant challenge Sunridge faced this year was the turnover in physicians. We had one full time academic physician retire and by June 30, 2015 we will have lost six other physicians for various reasons. Some have moved, some are taking advantage of opportunities to following their passions in other areas and others are looking at clinics closer to home. All of these physicians have provided excellence in patient care and resident/learner teaching and have been a pleasure to work with. Even though they will be missed, we are happy for them and the new paths they are exploring.

Sunridge is progressing towards a fully functional Patient Centred Medical Home. In line with this progression, Sunridge has several ongoing and new initiatives planned for 2015-2016. One future direction of the Health Management Program is to enhance teamwork and patient care through regular team meetings. Efforts are under way to develop in several areas (Mosaic PCN, PLC ER, Coagulation clinic, etc.) to develop more community partnerships in order to better respond to local needs.
Sunridge has three RNs (Health Management Nurses) running the health management program. The goal of this program is to help patients regain optimum health or improved functional capability, cost-effectively and in the right setting. The program focuses on the following categories of patients:

- High risk patients
- High utilization and high cost patients
- Poorly controlled patients
- Population management for specific groups we identify
- Transitional care management
- Complex conditions
The program is a patient centered, collaborative process between the patient, health management nurse, physician and the rest of the allied health team to promote positive patient outcomes. The health management nurses assist patients in achieving positive outcomes through:

- Comprehensive assessment of the patient’s condition
- Developing and implementing with the patient, a care management plan that includes patient goals, monitoring and follow-up
- Care coordination
- Health coaching
- Patient education regarding current health care and wellness options
- Advocacy
- Self-management support and shared decision making – helping patients to manage their own problems
- Complex care plans

The Health Management program was started with complex care plans using the following initiatives:

- One physician was chosen from each microsystem. Reports were run on each doctor’s panels by the clinic RN to identify which patients qualified for complex care plans
- The clinic LPNs called patients, explained the program and booked appointments.
- The doctors were matched with a health management nurse who worked on the same day allowing the patient to see the nurse and their doctor on the same day to provide timely, coordinated care
- Patients are scheduled for a one hour appointment with the health management nurse, than scheduled with their physician for a 15 minute appointment. Our goal and best practice is for the physician to pop into the conference room and meet with the patient and nurse as a team to review the complex care plan
The health management nurses refer directly to any of the allied health team based on their assessment. The nurse communicates the referral to the physician and has the patient follow-up as necessary with the physician. If at any time the health management nurse is unsure of best practice for the patient, they consult with the physician.

The health management nurses are now receiving referrals to the health management program from all physicians for case management.

Bi weekly meetings with the Health Management Program team are held to discuss process, workflow, schedule, challenges, positive outcomes and feedback.

Processes will be further defined as we continue to develop, implement and evaluate the program. A patient survey was created as a first step in the evaluation of the Health Management program.

The survey, conducted from March 4-31, 2015, was handed out to patients after their visit with the health management nurse and was completed in clinic prior to patient leaving. All surveys were kept anonymous.

- Total participants: 23 (9 males, 14 females)
- Age range: 33 yrs. – 85 yrs. Males (33 yrs. – 70 yrs.), Females (45 yrs. – 85 yrs.)
- Length of time seeing health management nurse: First visit (18); 1-6 months (1); No answer (4).
- There were a total of 13 questions. Patients would rate the question on six different response categories.
Overall, results were positive indicating the Health Management program was well received. Patients were satisfied with the management of their health needs, felt better able to cope with their health needs and to support lifestyle changes to keep themselves healthy. Patients stated they would recommend this service to their family and friends.

At the end of the survey, participants were free to add general comments about the program, and areas for improvements. Below is an overview of the comments received from patients.

*Health management nurses were very knowledgeable and informative. The nurses were conscientious, offered excellent information and suggestions. Patients felt their concerns were important. They felt making decisions on lifestyle changes and improving their health is best supported through guidance and education opportunities. They appreciated knowing about resources available in the community and in the clinic. They look forward to follow up sessions.*

The survey will be distributed again in Sept 2015 to evaluate the program six months after initiation.
Panel Management

All physicians at Sunridge are paneled. All Sunridge patients have a primary physician and many are also paneled to residents. Physician panel sizes have been actively monitored for at least one year. There is one physician at Sunridge currently accepting new patients.

Funding has been secured from Mosaic PCN for a primary care coordinator position. One of the roles for this position is panel management, including cleaning and managing physician panels on a routine basis.

Sunridge works collaboratively with South Health Campus Teaching Clinic on decisions to modify existing data in the EMR as the EMR is shared between Sunridge and SHC. In collaboration with SHC, we confirmed and defined patient status within the EMR. Strategy has been developed to address active/inactive patients.

All patients are divided into two categories based on age; less than 40 years old and greater than 40 years old. Each age category is further divided into two groups:

- Less than 40 years: seen in the clinic within the last 3 years = active, not seen in the clinic within 3 years = inactive.
- Greater than 40 years: seen in the clinic within the last 2 years = active, not seen in the clinic within 2 years = inactive.

The primary care coordinator will contact all patients listed as inactive to determine if they are still patients at Sunridge. Any patient classified as inactive who calls the clinic requesting an appointment with their doctor, will be reactivated. Further refinement of panels, including review of current diagnostic codes for specific conditions, will follow this initial panel cleanup.
RN Hired for Clinic

A Primary Care Nurse (RN) was hired for clinic support, projects and clinical education. The RN provides leadership to the clinic team of LPN’s, MOA’s and reception staff and is responsible for the overall day-to-day functioning of the clinical area, ensuring staff levels are adequate to maintain a safe environment for patients and staff.

The clinic RN is a key contributor to the development, implementation and evaluation of the health management program. The RN works closely with the health management team to ensure proper workflow and processes are in place.

The initial focus of staff education was to ensure AHS required Annual Compulsory Education (ACE) and staff immunizations were up to date as well as other annual education (CPR, N95, anaphylaxis and back care). The majority of staff are up to date on all compulsory education and immunizations.

Sunridge received a new Blood Glucose Meter from AHS. Initial education and certification was completed with all LPNs in March 2015.

The clinic RN facilitates coordination of research projects in the clinic and has been active in this role since starting in December 2014.

Teaching

Teaching Rounds

Teaching rounds are held two days a week to encourage discussion and collaboration among all health care providers at Sunridge. Residents, physicians and the allied health team all take turns presenting topics for discussion.

Topics, chosen by the presenters, are listed in the table below:
<table>
<thead>
<tr>
<th>Date</th>
<th>Teaching Rounds Topic</th>
<th>Group Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct. 21 &amp; 22, 2014</td>
<td>“Insulin In Practice: A Simplified Approach”</td>
<td>Pharmacist, Diabetes Nurse Educator</td>
</tr>
<tr>
<td>Oct. 28, 2014</td>
<td>“Transitioning After Residency”</td>
<td>Preceptor</td>
</tr>
<tr>
<td>Oct. 29, 2014</td>
<td>“Mobile Resources &amp; EMR”</td>
<td>Preceptor</td>
</tr>
<tr>
<td>Nov. 04, 2014</td>
<td>Review of CFPC Priority Topic: Chemic Heart Disease</td>
<td>MS 1 Resident</td>
</tr>
<tr>
<td>Nov. 05, 2014</td>
<td>Lower GI Bleeding in Children</td>
<td>MS 1 Resident</td>
</tr>
<tr>
<td>Nov. 12, 2014</td>
<td>&quot;Integrative Medicine&quot;</td>
<td>MS 2 Resident</td>
</tr>
<tr>
<td>Nov. 19, 2014</td>
<td>“Concussion”</td>
<td>MS 3 Resident</td>
</tr>
<tr>
<td>Nov. 25 &amp; 26, 2014</td>
<td>“Counselling Support at Sunridge”</td>
<td>Behavioural Health Consultant, Mental Health Therapist</td>
</tr>
<tr>
<td>Dec. 02, 2014</td>
<td>“Chronic Kidney Disease and the new Alberta Pathway”</td>
<td>MS 1 Resident</td>
</tr>
<tr>
<td>Dec. 03, 2014</td>
<td>&quot;Differential of an Infant Skin Rash&quot;</td>
<td>MS 1 Resident</td>
</tr>
<tr>
<td>Dec. 09, 2014</td>
<td>“Irritable Bowel Syndrome”</td>
<td>MS 2 Resident</td>
</tr>
<tr>
<td>Dec. 10, 2014</td>
<td>&quot;Management of Community Acquired Pneumonia as an Outpatient and When to Admit&quot;</td>
<td>MS 2 Resident</td>
</tr>
<tr>
<td>Dec. 16, 2014</td>
<td>“Mirena – New Insertion Kit” (Presentation and Demonstration)</td>
<td>Bayer Pharmaceutical Representative</td>
</tr>
<tr>
<td>Dec. 17, 2014</td>
<td>“Ring-a-ding-ding: Left sided weakness in a 46 year old&quot;</td>
<td>MS 3 Resident</td>
</tr>
<tr>
<td>Jan. 07, 2015</td>
<td>“Approach to Hypocalcaemia”</td>
<td>MS 1 Resident</td>
</tr>
<tr>
<td>Jan. 13, 2015</td>
<td>“The Shingles Vaccine”</td>
<td>Preceptor</td>
</tr>
<tr>
<td>Jan. 14, 2015</td>
<td>“Celiac Disease”</td>
<td>MS 2 Resident</td>
</tr>
<tr>
<td>Jan. 21, 2015</td>
<td>“Vitamin D Deficiency”</td>
<td>MS 3 Resident</td>
</tr>
<tr>
<td>Jan. 27, 2015</td>
<td>“Nutrition Education with Simple Games”</td>
<td>Dietician Living Well</td>
</tr>
<tr>
<td>Jan. 28, 2015</td>
<td>“Protecting Patient Privacy - Case Study”</td>
<td>Medical Social Worker</td>
</tr>
<tr>
<td>Feb. 04, 2015</td>
<td>“The Experience of New Family Medicine Faculty”</td>
<td>Search and Selection Candidate</td>
</tr>
<tr>
<td>Feb. 10, 2015</td>
<td>“Common Skin Disorders in Family Medicine”</td>
<td>MS 2 Resident</td>
</tr>
<tr>
<td>Feb. 11, 2015</td>
<td>“insomnia”</td>
<td>MS 2 Resident</td>
</tr>
<tr>
<td>Feb. 18, 2015</td>
<td>“Red Eye”</td>
<td>MS 3 Resident</td>
</tr>
<tr>
<td>Mar. 03, 2015</td>
<td>“Abnormal Head Shapes - Paediatrics”</td>
<td>MS 1 Resident</td>
</tr>
<tr>
<td>Mar. 04, 2015</td>
<td>“Restless Legs”</td>
<td>MS 1 Resident</td>
</tr>
<tr>
<td>Mar. 10, 2015</td>
<td>“Screening Tools for Domestic Violence in a Busy Family Practice”</td>
<td>MS 2 Resident</td>
</tr>
<tr>
<td>Mar. 11, 2015</td>
<td>&quot;CKD Screening in Diabetic Patients&quot;</td>
<td>MS 2 Resident</td>
</tr>
<tr>
<td>Mar. 17, 2015</td>
<td>Croup</td>
<td>MS 3 Resident</td>
</tr>
<tr>
<td>Mar. 24, 2015</td>
<td>Programs, Workshops and Classes Available to Patient</td>
<td>Chronic Disease Management and Pharmacist</td>
</tr>
<tr>
<td>Mar. 25, 2015</td>
<td>Health Management Nurse and Comprehensive Care Plans</td>
<td>Chronic Disease Management and Pharmacist</td>
</tr>
<tr>
<td>Mar. 31, 2015</td>
<td>Fundaments for MSK Radiograph Interpretation</td>
<td>Preceptor</td>
</tr>
<tr>
<td>Apr. 1, 2015</td>
<td>The New Oral Anticoagulants</td>
<td>Preceptor</td>
</tr>
<tr>
<td>Apr. 7, 2015</td>
<td>Dyspepsia</td>
<td>MS 1 Resident</td>
</tr>
<tr>
<td>Apr. 8, 2015</td>
<td>An Approach to Vertigo</td>
<td>MS 1 Resident</td>
</tr>
</tbody>
</table>
Attendance at the teaching rounds has been very good (average number is 7-12 participants) much higher than in previous years. Increase in attendance has improved the discussion and interaction amongst the team.

Pharmaceutical rep presentations are held three times a month where physicians, residents, allied health team and staff may all attend. Feedback on these presentations is that some of them have been quite useful.

Patient Education Classes

A “Living Well with Diabetes” class is provided to Sunridge diabetic patients by one of the health management nurses and the pharmacist (both diabetes educators) from the allied health team. The facilitators guide participants through various topics on the conversation map, encouraging questions, allowing participants to interact with one another and learn from each other. This teaching style is very different compared to traditional lecture/classroom learning allowing ample opportunity for visual learning and active dialogue. The participants valued the socialization/interactive aspect of the class and appreciated the support from each other. Overall, the feedback from the participants was very positive, emphasizing the value of providing this type of education. The class worked well in linking participants back into the medical home as most had 1:1 appointments with the allied health team in the clinic after the class for regular follow-ups. In the future we would like to offer more group classes to our diabetic population as well as other special populations unique to Sunridge.

The dietician at Sunridge provided interactive nutritional education classes called “Ask a Dietician”. Through the use of games the dietician showed innovative and fun ways to build a healthy meal. Participants’ feedback suggested that the sessions were both enjoyable and beneficial.

Learners[1] in Sunridge Clinic 2014:

- R1 (First year resident): 19
- R2 (Second year resident): 22
- Mandatory Clerks: 8
- Clerks (Elective): 5
- Visiting Clerks: 5
- Med 330: 14
- Med 430: 23
- Off-site residents: 3 (Remedial rotations)
- Externs: 3
CONTINUITY OF CARE

Sunridge continues to provide resident and physician templating for EMR continuity. Patients schedule appointments with the resident (secondary provider) assigned to them. Residents work mainly with their primary preceptor, providing continuity of patient relationships with residents and providers.

The number of appointment slots available for each resident per clinic is determined by the seniority of the resident (primarily status as R1 or R2) and the current Block rotation the resident is in and templated into the EMR. Slots can be adjusted as needed to match learner needs. Slots are 15 minutes in length, but adjacent slots in the appointment template can be combined to allow for longer visits as needed (PHE, counselling, etc.). Benchmarks are for slots of patient care, rather than patient numbers.

Below are the numbers of booking slots available per resident per clinic:

(R1) First year residents:
- Blocks 1-2 4 slots
- Blocks 3-6 6 slots
- Blocks 7-9 7 slots
- Blocks 10-13 8 slots

(R2) Second year residents:
- Blocks 1-9 8 slots
- Blocks 10-13 9 slots

Fit-ins are a common occurrence at Sunridge. Patients with urgent healthcare needs are seen same day. If a patient needs to be seen and their resident/provider is not in, the...
patient will be seen by another physician within their microsystem. If there is no capacity within the patients’ microsystem, the patient will be seen by another physician in the clinic. Physician absences are generally covered within the microsystem and supported by clinic administration.

All microsystems have regular meetings to discuss processes and patient care.

Patient care often continues beyond clinic hours. Physicians and residents stay until all patients have been seen and charting is completed. Some physicians will do home visits on days not in clinic.

Patients receive individualized personal care through staff continuity. Staff know patients by name and their healthcare concerns.

Sunridge has a large allied health team, consisting of a behavioural health consultant, mental health therapist, mental health consultant-shared mental health, certified respiratory nurse educator, pharmacist, social worker, diabetes nurse educator, dietician and three health management nurses. The Health management nurses work collaboratively with the allied health team on site to provide comprehensive care and continuity of care to those most in need. The primary care coordinator position will ensure continuity through referral to the allied health team on site. Team meetings involving the patient will occur on a regular basis.

Central referral maintains an accurate and up to date database of specialists and specialty clinics. Patients are referred back to specialists they have seen in the past to provide continuity of care over time.

**Community Initiatives**

Peter Lougheed Hospital emergency department negotiated with Sunridge for influenza “A” patients to be seen at Sunridge to decrease volume in the emergency department. Volume of influenza “A” referral patients were low and there were easily fit into physicians’ clinics. Further discussions are underway to consider further partnerships in this area.
A new initiative was created with Anticoagulation Management Services where their unattached patients ready for discharge are provided a family physician within Sunridge. Sunridge has been actively involved with several Mosaic PCN initiatives and is actively involved in other areas of PCN development, including a Sunridge physician on the PCN board.

CHALLENGES

The turnover in physicians this past year has been the greatest challenge at Sunridge. Sunridge integrated three new teaching physicians and are in the process of recruiting four more. This integration included the transition of patient panels and residents into other physician’s panels and clinics presenting a challenge for patients, residents, physicians and staff. Sunridge is working to ensure the transition is smooth for all involved. Patients are reassured they will have a family physician if they choose to stay at Sunridge for their care. Residents and staff have been given as much notice as possible in regards to the changes and who they will be working with. New physicians are given increased training and orientation to ensure they are comfortable in their new environment and positions.

Other challenges Sunridge faced over the last year are:

- Capacity to evaluate, clinic processes, patient care and initiatives due to the lack of IT resources and trained staff to assist in running reports and generating metrics. Sunridge has two super users who have received some training in running reports but further training is required. A third super user has recently started training.
- Capacity to manage physician panels has been a challenge due to the lack of IT resources and staffing. Sunridge is in the process of hiring a primary care coordinator who will be responsible for cleaning and managing physician panels on a routine basis. We are predicting that one primary care coordinator position will not be enough for the size of Sunridge and the job expectations for this role.
- Number of off schedule residents at Sunridge makes scheduling a challenge.
- Number of patients with English as a second language. We currently have two physicians and three staff that speak other languages so they are able to care for most of our patients with English as a second language. Cordless phones have been installed in each teaming room for translation services. We have some patient education information in Spanish and are looking at getting more information in other languages.
- Parking is a challenge for all patients but in particular is an issue for our seniors and handicap patients. There are only 3 handicap stalls and the signs are often knocked down. Impark is slow to replace them. In the winter with no signs and snow covering the ground, the handicap stalls
A Clinic Improvement Team (CIT) was established at Sunridge in January 2014 with the aim of promoting and supporting quality improvement initiatives. The Clinic Improvement Team’s mandate is to assess, evaluate and implement projects that will lead to improvement in overall care and education. The CIT is a multidisciplinary group consisting of the clinic manager, clinic RN, site medical lead, academic service planning consultant, physician, resident representative, LPN, MOA, reception, clinic scheduler and administration.

One of the first projects under exploration by the CIT has been evaluation of stocked inventory in exam rooms. Concerns were raised regarding excessive stocking in exam rooms which were leading to a high volume of unused supplies being thrown out due to expiration. The stocking of exam rooms was thus brought under scrutiny and analyzed in relation to the amount that was being stocked versus the amount that was expiring and being thrown out. This has been an essential project for the clinic because there were also concerns raised about the possibility of using expired supplies on patients. Sunridge’s goal is to balance clinic costs for supplies in relation to adequately meeting patient needs without compromising care. Members of the CIT came up with a list of recommended quantities for each supply. Currently the different Microsystems are running trials in their exam rooms based on this list. A future goal of the committee will be to evaluate whether this list has been helpful in reducing wastage of extra supplies as well as explore further directives in this field.

Another important project by the committee is reducing patient wait times. In this aspect, posters have been put up around the clinic asking patients to arrive 15 min prior to their scheduled appointment. In addition to this cycle times at the clinic are being monitored at three month spans in order to improve access.

The team will also be involved in the implementation and evaluation of projects such as the Health Management Program, ASaP, and EMR related projects, with the goal of improving our patient centered medical home.

On the education front, roadmap and documentation has been created for incoming residents to plan their QI projects in an organized manner. This will help residents gain support from the CIT in terms of resource planning, local relevance of projects and removing obstacle to successful completion of their projects.
Future Directions & Initiatives

- **Health Management Program**
  
  Future direction for this program includes:
  
  - Development of standing orders (standard care plans) for the health management nurses to adjust treatment within specific parameters, allowing them to practice to their full scope.
  - Establishment of a dedicated Health Management team, which includes providing a secure time and place for all members of the health care team, including the patient, to meet together to discuss patient care.
  - The Patient Care Coordinator will eventually be a single point of contact for patients and staff to arrange appointments with the health management nurse.
  - More in-depth evaluation, in collaboration with the Mosaic PCN, including monitoring healthcare indicators such as: BP, A1Cs, waist circumference, etc.

- **Panel Management**
  
  The primary care coordinator will clean and monitor physician panels on a routine basis. They will act as a panel management resource to the team including submitting monthly panel reports, be a key member in the identification of patients qualifying for the health management program and participate on a team for data collection and programmatic evaluation related to the Patient Centered Medical Home and quality improvement initiatives.

- **Initiation of ASaP**
  
  Plan is for the initiation of ASaP in Sunridge in the fall of 2015.

- **Emergency Department (ED) to Primary Care**
  
  Sunridge has entered discussion with Calgary Zone Primary Care Team, Calgary Zone PCNs, Calgary Zone Emergency Department and CZ Health link Alberta to assess the feasibility of Sunridge being a part of the ED to Primary Care initiative. The purpose of the initiative is to refer patients presenting to the Peter Lougheed Hospital ED with non-urgent issues to the Sunridge clinic to be seen by our primary care physicians, to decrease volume in the ED and improve patient access to care.

- **Med Reconciliation**
  
  Sunridge would like to establish a med reconciliation program, but this initiation would require more pharmacy time. Currently Sunridge has a pharmacist on site one day a week.

- **Staff Clinical Education**
  
  The clinic RN is working in collaboration with the RN’s from the other two DFM teaching clinics to share ideas and resources on department related competencies. Learning activities for the clinic staff are being developed in the following areas: ear irrigation, performing ECG’s, IP&C, measuring vital signs, documentation, sterile technique, back safety and urinalysis.
The Patient and Citizen Innovation Council in Family Practice: Ron Garnett M.D., CCFP(EM), FCFP, Site Medical Lead Academic Family Medicine South Health Campus, Calgary; Jane Bowman R.N., M.N., Manager Academic Family Medicine South Health Campus, Calgary; Joanne Ganton B.Comm., Manager Patient Family Centred Care South Health Campus, Calgary 2014

Guide to Panel Identification for Alberta Primary Care, April 2014

Family Practice: The Patient’s Medical Home — Objectives and Goals. September 2011; A Vision for Canada Family Practice — The Patient’s Medical Home

Workforce Planning
WORKFORCE PLANNING

CURRENT WORKFORCE

The DFM workforce consists mainly of family physicians aged 49 years old or younger. The majority of family physicians with a primary appointment are female (57%).

![Primary Appointments - Age and Gender](chart)

PCN PARTICIPATION

Calgary Zone Primary Care Networks and the Department of Family Medicine continue to build connections with family physicians. The following graph shows the participation of family physicians in each of these groups.

![DFM and PCN Participation](chart)
WORKFORCE PLANNING

PHYSICIAN RECRUITMENT ACTIVITIES

The Department of Family Medicine (DFM) in Calgary has developed a reputation among physicians of being a supportive environment for physicians desiring to relocate to Calgary. Over the last 14 years the DFM has worked to provide one-on-one support, relevant information regarding opportunities, practice readiness information and an overview of how the DFM functions within the City, Zone and Provincial Alberta Health Services. The key role of the DFM through the Physician Recruitment Coordinator has been to assist physicians to navigate a process that can prove to be complicated and challenging to physicians relocating or for new graduates ready to enter practice in Calgary.

The recruitment initiatives of the DFM align with the Medical Home Model that encourages, timely access to primary care services, allows for comprehensive care and continuity of care where each patient has their own family physician in Calgary.

In the past year over 210 physicians contacted the DFM for support to find opportunities to practice within the sections of family medicine. From April 1, 2014 to March 31, 2015 over 40 physicians have been recruited to work in many different sections and areas of interest. The Physician Recruitment Coordinator (PRC), Darlene Befus, has met with many of these personally and communicates by phone and email to find practice opportunities within Calgary for these physicians. She connects those with focus practice such as hospitalist to the appropriate section and works with the sections to ensure a smooth transition for the relocating physician. A number of the physicians have been able to take advantage of Alberta Health Service (AHS) funding for visits and relocation (a two year return of service required), based on AHS policy and DFM guidelines.

The DFM and the Primary Care Networks have taken a collaborative approach to recruitment in Calgary. The DFM connects physicians with the PCN in the appropriate areas of the city to explore opportunities and services and the PCNs connect physicians with the DFM to provide visit and relocation support and for an introductory meeting to discuss family medicine in Calgary.

Once again this year the FM Residency program incorporated, as part of their academic half-day, the opportunity for the DFM to speak to the FM residents about transition to practice covering everything from opportunities, privileging and practice readiness. Our Physician Recruitment Coordinator meets with many of the new grads who desire to stay in Calgary, to talk about the opportunities and connect each graduating resident according to their area of interest.

The landscape of physician recruitment is ever changing with the needs in specialized practice areas often changing from year to year. During the past 18 months there have been limited opportunities in some desired area of practice (i.e. maternal newborn care, women’s health etc.) specifically for new grads. Community practice opportunities continue to be available with over 50 practices advertising on our family medicine website www.calgaryfamilymedicine.ca for full-time or part-time positions.

In September of 2014 the Urban Locum Program was discontinued after 12 years of service to family physicians in Calgary. The DFM has continued to support community family physicians by advertising their opportunities on the website and providing them with a list of physicians who have expressed
interest in providing locum coverage. There are currently over 30 locum opportunities on the DFM website.

On September 29, 2014 157 medical students, residents and practicing family physicians attended the 14th Annual Family Medicine Showcase with 68 booths displaying supports, services and opportunities available to family physicians. This event has become a highlight for many of the attendees and has serves to promote and support family medicine within Calgary.

The DFM continues to have a presence at the family physician conferences such as the Family Medicine Forum and the Annual Scientific Assembly in Banff, to promote Calgary to the physician attendees.

Our Physician Recruitment Coordinator also works with the Academic DFM to recruit physicians for the academic three teaching clinics. Checklists and processes have been implemented to ensure the recruitment process is a fair and transparent with each new physician receiving consistent orientation to the teaching clinics. Two academic conferences were attended to promote teaching opportunities in Calgary,

Recruiters have an important role in supporting physicians to transition from one community to the other. New graduates, especially, expect that there will be someone to support them to transition in to practice and many practicing family physicians now look for the point of contact to assist them as they move from around the world and across our country.
Appendices
EXAMPLES DEMONSTRATING MEDICAL HOME PILLARS

Integration of Patient’s Medical Home Model within the Department of Family Medicine

Goal 1:
Patient Centered Care
Patient care being responsive to patient attitudes, preferences and experiences. Person focused rather than disease focused.

Primary Care Network Collaborative Initiatives (Maternal Newborn Care) 32
Grief Support Program (Palliative Care) 67
Advanced Care Planning, Goals of Care Designation (Palliative Care) 70
Provincial Palliative Program (Palliative Care) 75
Palliative Home Care (Palliative Care) 77
East Calgary Family Care Clinic (Community Primary Care) 99
Playing an Integral Role in Ensuring Every Patient Has a Family Physician (Academic FM – Postgraduate Program) 121
Goal 1: Patient Centred Care (Academic FM – South Health Campus Family Medicine Teaching Clinic) 139
Health Management Program (Academic FM – Sunridge Family Medicine Teaching Clinic) 155

Goal 2:
Personal Family Physician
PMH will ensure every patient has a personal family physician.

Continued Physician Recruitment (Seniors Care) 93
Find a Doctor Web Registry (Community Primary Care) 100
Medical Home Working Group (Community Primary Care) 101
Path to Home Discharge Pilot Project (Community Primary Care) 102
Graduating Highly Trained Family Physicians (Academic FM – Postgraduate Program) 120
Playing an Integral Role in Ensuring Every Patient Has a Family Physician (Academic FM – Postgraduate Program) 121
Advances in Panel Management (Academic FM – Central Family Medicine Teaching Clinic) 133
Goal 2: Personal Family Medicine (Academic FM – South Health Campus Family Medicine Teaching Clinic) 140
Panel Management (Academic FM - Sunridge Family Medicine Teaching Clinic) 158
Community Initiatives (Academic FM – Sunridge Family Medicine Teaching Clinic) 164
Goal 3:

Team Based Care
PMH offers broad scope of services carried out by teams or networks working together.

- Best Sedative and Antipsychotic for the Elderly (Medical Inpatient Care) 41
- Palliative Consult Teams (Palliative Care) 67
- Grief Support Program (Palliative Care) 67
- Intensive Palliative Care Unit (Palliative Care) 71
- Hospices (Palliative Care) 73
- Tom Baker Consult Service (Palliative Care) 76
- Palliative Home Care (Palliative Care) 76
- Community Paramedic Program (Seniors Care) 94
- East Calgary Family Care Clinic (Community Primary Care) 99
- Medical Home Working Group (Community Primary Care) 101
- Happiness Basics/Mental Health (Community Primary Care) 102
- Path to Home Discharge Pilot Project (Community Primary Care) 102
- Playing an Integral Role in Ensuring Every Patient Has a Family Physician (Academic FM – Postgraduate Program) 121
- Staffing Workforce Re-Design (Academic FM – Central Family Medicine Teaching Clinic) 131
- Goal 3: Team Based Care (Academic FM - South Health Campus Family Medicine Teaching Clinic) 143
- Health Management Program (Academic FM – Sunridge Family Medicine Teaching Clinic) 155
- RN Hired for Clinic (Academic FM – Sunridge Family Medicine Teaching Clinic) 159
- Patient Education Classes (Academic FM – Sunridge Family Medicine Teaching Clinic) 161
- Community Initiatives (Academic FM – Sunridge Family Medicine Teaching Clinic) 163

Goal 4:

Timely Access
PMH will ensure timely access to appointments.

- Rapid Access Unit (Medical Inpatient Care) 50
- Intensive Palliative Care Unit (Palliative Care) 71
- Palliative Home Care (Palliative Care) 77
- Find a Doctor Web Registry (Community Primary Care) 100
- Medical Home Working Group (Community Primary Care) 101
- Path to Home Discharge Pilot Project (Community Primary Care) 102
- Path to Care (Community Primary Care) 104
- Staffing Workforce Re-Design (Academic FM – Central Family Medicine Teaching Clinic) 131
- Goal 4: Timely Access; Coordination of Care (Academic FM - South Health Campus Family Medicine Teaching Clinic) 146
- Health Management Program (Academic FM – Sunridge Family Medicine Teaching Clinic) 155
- RN Hired for Clinic (Academic FM – Sunridge Family Medicine Teaching Clinic) 159
Goal 5: Comprehensive Care

PMH will provide patients with a comprehensive scope of services.

Provincial Palliative Program (Palliative Care) 75
Tom Baker Consult Service (Palliative Care) 76
Palliative Home Care (Palliative Care) 77
Path to Care (Community Primary Care) 103
Graduating Highly Trained Family Physicians (Academic FM – Postgraduate Program) 120
Playing an Integral Role in Ensuring Every Patient Has a Family Physician (Academic FM – Postgraduate Program) 121
Staffing Workforce Re-Design (Academic FM – Central Family Medicine Teaching Clinic) 131
Facility Enhancements and Supply Management Improvements (Academic FM – Central Family Medicine Teaching Clinic) 134
Goal 5: Comprehensive Care (Academic FM – South Health Campus Family Medicine Teaching Clinic) 147
Health Management Program (Academic FM – Sunridge Family Medicine Teaching Clinic) 155
RN Hired for Clinic (Academic FM – Sunridge Family Medicine Teaching Clinic) 159
Patient Education Classes (Academic FM – Sunridge Family Medicine Teaching Clinic) 161

Goal 6: Continuity of Care

PMH will provide continuity of care, relationships and information.

Women's Health Ambulatory Care (Maternal Newborn Care) 31
Transfer of Care Communication Update (Medical Inpatient Care) 44
Alberta Referral Pathways (Community Primary Care) 104
Playing an Integral Role in Ensuring Every Patient Has a Family Physician (Academic FM – Postgraduate Program) 122
Staffing Workforce Re-Design (Academic FM – Central Family Medicine Teaching Clinic) 131
Advances in Panel Management (Academic FM – Central Family Medicine Teaching Clinic) 133
Goal 6: Continuity of Care, Relationships and Information (Academic FM – South Health Campus Family Medicine Teaching Clinic) 148
Health Management Program (Academic FM – Sunridge Family Medicine Teaching Clinic) 156
RN Hired for Clinic (Academic FM – Sunridge Family Medicine Teaching Clinic) 159
Continuity of Care (Academic FM – Sunridge Family Medicine Teaching Clinic) 162
Goal 7:  
**Electronic Medical Records**

PMH will maintain electronic medical records for patients. Assist in understanding overall practice and community needs.

- Transfer of Care Communication Update (*Medical Inpatient Care*)
- Goal 7: Electronic Medical Records (*Academic FM – South Health Campus Family Medicine Teaching Clinic*)
- Panel Management (*Academic FM - Sunridge Family Medicine Teaching Clinic*)
- Continuity of Care (*Academic FM – Sunridge Family Medicine Teaching Clinic*)

Goal 8: Education, Training & Research

PMH will serve as sites for training students and residents and are conducive to research activities.

- Academic Engagement (*Maternal Newborn Care*)
- Bedside Ultrasound Certification Course (*Maternal Newborn Care*)
- Pregnancy Parables (*Maternal Newborn Care*)
- Teaching (Residency Program and Medical Students) (*Medical Inpatient*)
- Urgent Care Rounds, e-simulation (*Urgent Care*)
- Intensive Palliative Care Unit (*Palliative Care*)
- Academic Palliative Medicine (*Palliative Care*)
- Undergrad Medicine Electives (*Palliative Care*)
- Continuing Medical Education (*Palliative Care*)
- Continuing Medical Education (*Seniors Care*)
- 48th Annual Mackid Symposium (*Community Primary Care*)
- Faculty Development (*Academic FM- Continuing Professional Development*)
- Family Medicine/Rural Medicine Interest Group (*Academic FM – Undergraduate Program*)
- MedZero (*Academic FM – Undergraduate Program*)
- Family Medicine Clinical Experience (MDCN 330 or 430) (*Academic FM – Undergraduate Program*)
- Evidence Based Medicine (MDCN 440) (*Academic FM – Undergraduate Program*)
- Family Medicine Clerkship (MDCN 502) (*Academic FM – Undergraduate Program*)
- Goal 8: Education, Training & Research (*Academic FM – South Health Campus Family Medicine Teaching Clinic*)
- RN Hired for Clinic (*Academic FM – Sunridge Family Medicine Teaching Clinic*)
- Teaching Rounds (*Academic FM – Sunridge Family Medicine Teaching Clinic*)
Goal 9:

**Evaluation**

PMH will carry out ongoing evaluation of effectiveness of its services as part of its commitment to QI.

- Collaborative Care Project *(Maternal Newborn Care)*
  - Page 28
- Periodic Review Electronic Process *(Maternal Newborn Care)*
  - Page 32
- Reportable/Adverse Event Framework *(Maternal Newborn Care)*
  - Page 34
- South Health Campus Rapid Access Unit (RAU) Evaluation *(Medical Inpatient)*
  - Page 38
- Readmission Rates *(Medical Inpatient)*
  - Page 40
- Hospices *(Palliative Care)*
  - Page 73
- Provincial Palliative Program *(Palliative Care)*
  - Page 75
- Appropriate Use of Antipsychotics *(Seniors Care)*
  - Page 93
- Staffing Workforce Re-Design *(Academic FM – Central Family Medicine Teaching Clinic)*
  - Page 131
- Facility Enhancements and Supply Management Improvements *(Academic FM – Central Family Medicine Teaching Clinic)*
  - Page 134
- Goal 9: Evaluation *(Academic FM – South Health Campus Family Medicine Teaching Clinic)*
  - Page 150
- Health Management Program *(Academic FM – Sunridge Family Medicine Teaching Clinic)*
  - Page 156

Goal 10:

**System Supports**

Governance policies and practices in place.

- Collaborative Care Project *(Maternal Newborn Care)*
  - Page 28
- Communication Survey *(Maternal Newborn Care)*
  - Page 28
- Periodic Review Electronic Process *(Maternal Newborn Care)*
  - Page 32
- Reportable/Adverse Event Framework *(Maternal Newborn Care)*
  - Page 34
- Leadership Development – Deputy Site Leads *(Maternal Newborn Care)*
  - Page 52
- Urgent Care Review Implementation *(Urgent Care)*
  - Page 61
- Continued Physician Recruitment *(Seniors Care)*
  - Page 93
- Physician Web Registry *(Community Primary Care)*
  - Page 97
- DFM HomePage – E-newsletter *(Community Primary Care)*
  - Page 97
- Medical Home Working Group *(Community Primary Care)*
  - Page 101
- Goal 10: System Supports *(Academic FM – South Health Campus Family Medicine Teaching Clinic)*
  - Page 152
DFM SCHOLARLY ACTIVITY

ACADEMIC DFM SCHOLARLY ACTIVITY
(JULY 1, 2014-JUNE 30, 2015)

GRANTS


Crowshoe L.  First peoples, second class treatment: Examining the role of racism in the health and well-being of Indigenous peoples.  *CIHR Meeting Grant* $12,000. Sep 1, 2014 to Sep 30, 2015.

Crowshoe L.  Case Managers to improve management of Arthritis and associated comorbidities with Aboriginal communities: A proof of concept study.  *Canadian Initiative for Outcomes in Rheumatology Care (CIORA)* $120,000. July 1, 2014 to June 30, 2016.


PUBLICATIONS


Kelly M. From acquisition to participation: theorizing virtual patient use in family medicine education. Family Medicine Oct 201; 46(9): 734.


Ponka D, Dickinson J. Five things to know about; screening with the Pap test. *Canadian Medical Association Journal* Dec 2014; 186(18).


Shaw M, Rypien C, Drummond N, Harasym P, Nixon L. Seniors’ perspectives on care: a case study of


**Publications in Press**


Bell K, Del Mar C, Wright G, **Dickinson J** and Glasziou P. Prevalence of incidental prostate cancer:


Tonelli M (PI), Braun T (Co-I) et al. "Epidemiology; costs and consequences of multimorbidity." 2012-2014. $320,750. Canadian Institute for Health Research.


Chary S (PI), et al. "School Children and Their Understanding of “Major Change or Losses in Life” and How They Communicate With Their Parents and Teachers to Improve Coping and Life Skills." 2015. $25,000. Pallium Foundation of Canada.


Simon J (PI), Sinnarajah A (Collaborator) et al. "Division of Palliative Medicine Research Assistant Support Funding". 2014-2015. $ 47,000. Alberta Cancer Foundation.

Simon J (Co-PI), Wasylenko E (Collaborator) et al. “Advance Care Planning and Goals of Care Alberta: A Population Based Knowledge Translation Intervention Study” 2013-2018. $2.5 million. Collaborative Research and Innovation Opportunities, Alberta Innovates Health Solutions.

Read Paul L (PI), Spice R (Co-I), Sinnarajah A (Co-I) e al. "Web-Based Videoconferencing (WBVC) for Rural Palliative Care Consultation in the Home". 2015. $20,000. Technology Evaluation in the Elderly Network (TECHVALUENET).


**Publications**


Sweet L, Adamis D, Meagher DJ, Davis D, Currow DC, Bush SH, Barnes C, Hartwick M, Agar M, Simon J, Breitbart W, MacDonald N, Lawlor PG. Ethical challenges and solutions regarding delirium studies in


