UNIVERSITY OF CALGARY

Alberta Health Services

Department of Family Medicine

2020-2021 Annual Report

Vision

A community of Family Physicians and Primary Care Providers building collaborative, integrated, and innovative medical homes, responsive to the needs of our population.

Mission

To Serve Our Communities:

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

DFM Leadership:

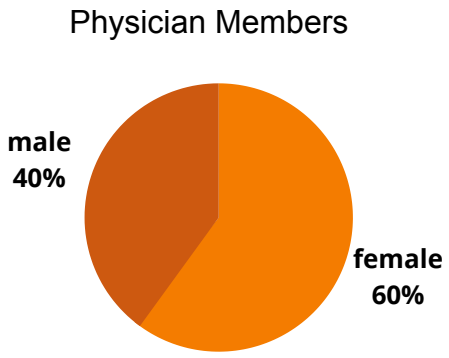
Academic Department Head: Dr. Sonya Lee
Clinical Department Head: Dr. Mike Spady
Deputy Academic Department Head: Dr. Maeve O'Beirne
Deputy Clinical Department Head: Dr. Ann Vaidya
Department Manager: Ms. Allison Mirotchnik, Ms. Diana Trifonova (Effective April 28, 2021)

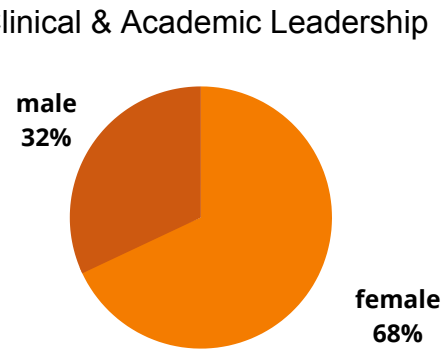
Unless otherwise stated, the work presented within this report occurred between April 1, 2020 and March 31, 2021.

Executive Summary

As the global COVID-19 pandemic continues to dominate our lives and work, we nevertheless remain hopeful as we progress with vaccination and management of COVID-19 and post-COVID disease. With an optimistic view for the next year, we present our Annual Report for 2020-2021 acknowledging the enormous efforts of our physicians and staff over the past 18 months, and their continued focus on developing, promoting, and modelling the principles of Family Medicine and the Patient Medical Home (PMH). Within this report are examples of courageous and dedicated health care workers in our sections, and incredible connections and collaborations with our Acute Care, Community and PCN partners.

We are a Medical Affairs department with almost 1,300 members, in six clinical sections. We continue to have a progressive gender balance in our membership, with a huge variety of practice types and clinical activity. Over 85% of our physicians maintain an academic appointment and participate in health learner education on multiple fronts. We are also proud of our gender balance in the department in membership and at leadership tables. We look forward to continuing conversations around how to better understand and address Equity, Diversity and Inclusion issues in both arms of our Department.





Highlights, Accomplishments, Challenges

Highlights this year from our Community Section include a shift toward a virtual Mackid CME event focused on physician wellness and continued adaptation to the new reality of virtual care as part of daily practice and patient expectations. The DFM has a unique role within the Calgary PCN structure as primary care partners within the AHS system; the impact of the Calgary Zone PCN committee work through the primary care task groups continues to show exponential benefits to the system and to Albertans, and the DFM is proud to be partners and liaisons in this work. Another significant challenge is the external demand on primary care, as a large pool of generalist-trained physicians who can support needs in other care domains. We continue to balance the priority of building strong medical homes in the community and contributing to generalist family medicine neighbourhoods in other sections, by responding to requests from our specialty partners to support acute care specialty extender work, COVID-19 care in hospital, transitions management, and shared care.

COVID-19 care in the community has required innovative changes in practice and approach, from a massive shift to virtual visits that continues to be valued by patients even as COVID-19 numbers decline, to our inner-city community primary care partners managing an Assisted Supervised Isolation Site (ASIS) to help marginalized and homeless individuals have a safe place to isolate or quarantine and still have their often significant health care needs addressed. Our PCNs shifted to manage ill patients in their after hours Access Clinics, and ensure follow-up and management of all identified COVID-19 positive patients in the Calgary Zone. This massive collaborative approach has resulted in Calgary having the highest rate of COVID-19 managed in the community across the province.

of all COVID-19 cases cared for in the community including LTC

Our Maternal Newborn section continues to provide high quality care to over 40% of all pregnant families in the Calgary Zone, with multiple quality improvement activities and continued movement toward standardized workforce management. One of the main challenges for this section is the decreasing birth rate and changing expectations of Albertans around prenatal, delivery and post-natal care. Collaborations with midwifery and obstetrics around these issues are ongoing. COVID-19 has provided a particular challenge with limitations on visitation, patient fear of going into our facilities, and the challenges with proper personal protective equipment management in an extremely dynamic and at times unpredictable clinical environment. COVID-19 care for pregnant women is an evolving area of focus with different needs and concerns, and COVID-19 vaccination has required a communication and expertise focus to support difficult conversations with their clients.

Medical Inpatients (Hospitalists) admit and manage approximately 58% of all medical admissions in the Calgary Zone and provide high quality care with regular reporting on metrics vital to the acute care system. These include ALOS/ELOS ratios of 0.99 to 1.1 while maintaining 7-day readmission rates of around 4%. Our hospitalist colleagues collaborated tightly with Seniors Care in many innovative arrangements that decrease ED visitations and hospitalizations for frail seniors, and worked quickly in the spring to develop capacity plans for COVID-19 that remain in place as we moved through a second and third COVID-19 wave. They have adapted and innovated quickly, adjusting shift hours and focus, while also helping other departments manage significantly increased admission numbers during the second and third waves of the pandemic in Alberta. High levels of collaboration with Psychiatry, Emergency Medicine, and Internal Medicine; quick responses to facility COVID-19 outbreaks; and continued work with ASIS during COVID-19 have been a key part of our zonal COVID-19 response. This includes many of our hospitalist colleagues and other Family Medicine members working on COVID-19 units in our hospitals.

Our Urgent Care section represents the two urban sites, Sheldon Chumir and South Calgary Urgent Cares. Highlights include a strategic plan development with multiple stakeholders prior to COVID-19, and a focus on physician wellness and support. There is now more clarity and certainty around the launch of Connect Care with a planned date in November 2021. Preparations for a successful implementation are well underway and we thank some of our members who have gone to the North Zone to support the implementation of Wave 2. Their experiences there will undoubtedly be immensely valuable to our launch later this year. While patient presentations dropped at all Urgent Care sites over the course of the first and second waves of COVID-19, there has been a steady progression in numbers and acuity as we move into the third wave. Both sites had quickly adapted to develop COVID-19 surge plans and adjusted schedules and rotations to manage the changes in volume. The need for continued flexibility in an uncertain environment and managing the launch of a major IT project will be challenging in the coming months.

The Palliative Care section has continued to serve urban and rural Calgary Zone clients through a difficult stage of life during a very turbulent time. They continue to focus on strategic activities that advance care in this area including early palliative care involvement in patients diagnosed with cancer, standardized hospice guidelines, and patient-centred care initiatives. They have seen particular challenges in recruiting palliative-trained physicians, as well as navigating the restrictions that COVID-19 has created for family participation and visitation and home palliative care. Palliative Care physicians will be part of the Wave 4 Connect Care launch in November 2021 and are preparing their members for the implementation across some of their sites in urban Calgary, and all rural sites. This is a particular challenge due to the distributed consultation model that will require knowledge and usage of more than one platform for a period of time between waves. With the visible development of the new Cancer Centre at the Foothills site, the Palliative Care section is looking forward to how the evolution of this new facility will affect delivery of palliative care in the Calgary Zone.

Our Seniors Care section continues to work on many initiatives looking at improving care at home for seniors and reducing ED visits and hospital admissions through multiple innovative projects. Of all our sections, this group has been the most significantly affected by COVID-19 with multiple outbreaks at LTC facilities early in the pandemic. With many units in lockdown, managing physician workforce had been challenging, and the loss these physicians and allied health providers have experienced in their patient population is profound and very personal. As we come out of the second wave of COVID-19 and see the effects of vaccination in long term care centres in the first phase of vaccine delivery in January, it is immensely relieving and gratifying to see case numbers drop to near zero at these sites. With a sense of hope, seniors physicians and staff continue to provide excellent care, doing everything possible to maintain individuals in their homes or facilities where safe and working together with families to reconnect after a very long period of increased isolation and fear. The very human effect of COVID-19 has been most felt in this section.

The Academic Department continues to care for over 27,000 paneled patients across three teaching sites in a PMH model. This model of accessible, continuous, comprehensive, and interdisciplinary care that is patient and family centred became even more important during the COVID-19 pandemic. The teaching sites maintained high levels of access and continuity throughout the pandemic. Our PMH model supported the immediate shift to virtual care in March-April 2020, enabled our ability to care for approximately 1000 COVID-19 positive patients in our panels, and supported the delivery of vaccines to our most at risk populations. We continue to train large numbers of residents, clerks and undergraduate medical students. Due to COVID-19, this was both a both a challenge and a success for our education programs and preceptors. Adaptability and partnerships supported an immediate shift to virtual curricula, the reorganization of clinical learning experiences in both the community and acute care sites, and the rapid introduction of virtual care in clinical teaching. And finally, our research teams adapted and secured funding for multiple new COVID-19 related projects and initiatives with the hope of improving our understanding of the COVID-19 pandemic in primary care.

A WEEK IN THE LIFE:
DFM Academic Physician - Clinician Educator

DAILY HUDDLE

The PMH team meets before each clinic to discuss the scheduled patients and their needs, review any issues related to preventive care, and review the health needs of the patient panel.

CLINICAL

SUPERVISION OF **2** RESIDENTS AND **1** MEDICAL STUDENT

51 PATIENT VISITS

>10% PATIENTS HAVE 2+ CHRONIC DISEASES

5 URGENT FIT-IN APPOINTMENTS

5 PAPs, IUD insertion biopsy/injection/ sutures PROCEDURES PERFORMED

36 PREVENTATIVE SCREENING RESULTS MANAGED

74 LAB RESULTS MANAGED

17 REFERRALS TO PMH TEAM & SPECIALISTS

5 HOME/LTC VISITS

AFTER HOURS CARE

1 EVENING CLINIC OR **1** MD24 CALL

3 FOLLOW UP CALLS AFTER CLINIC HOURS

15 COVID-19 PATHWAY CALLS

EDUCATION

COMPETENCY COACH

8 Field Notes

2 Progress Reviews

MENTORING

TEACHING

1 Virtual Small Group Teaching Session

RESIDENCY DIVISION DIRECTOR

- Oversight for 68 residents
- Manage resident assessments & progress
- Resident wellness
- Remedial/probation learners
- Liaise with preceptors
- Contribute to residency leadership

RESEARCH & SCHOLARSHIP

Collaboration with DFM & CSM Institute Researchers

ADMINISTRATION

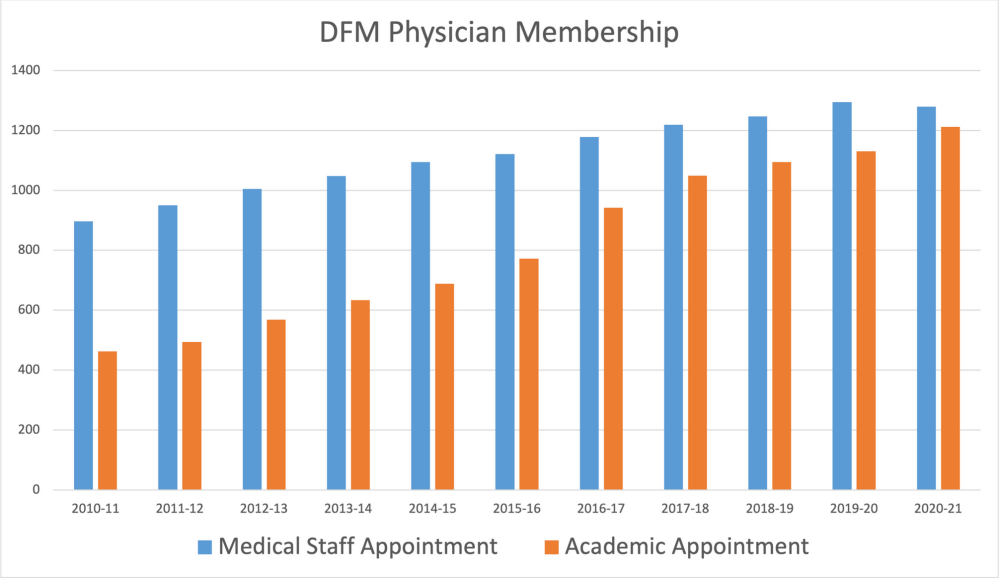
Boards & Committee Work, e.g.:
PCN ACFP CFPC
CPSA AMA

Contents

Legend/Acronyms

AHS = Alberta Health Services
AIMG = Alberta International Medical Graduate
ALOS/ELOS = Actual Length of Stay/Estimated Length of Stay
ARP = Alternative Relationship Plan
ASaP = Alberta Screening and Prevention Program
ASIS = Assisted Supervised Isolation Sites
CaRMS = Canadian Resident Matching Service
CBME = Competence BasedMedical Education
CCFP = Certification in College of Family Physicians
CFMTC = Central Family Medicine Teaching Centre
CFPC = College of Family Physicians of Canada
CII/CPAR = Community Information Integration/Central Patient Attachment Registry
CME = Continuing Medical Education
CPD = Continuing Professional Development
CSM = the Cumming School of Medicine
DFM/the Department = the Department of Family Medicine
DLRI = Distributed Learning and Rural Initiatives
DI = Diagnostic Imaging
ECFCC = East Calgary Family Care Clinic
ED = Emergency Department
EMR = Electronic Medical Record
EMS = Emergency Medical Services
EPAs = Entrustable Professional Activities
ERHL = Elbow River Healing Lodge
ES = Enhanced Skills
FMC = Foothills Medical Centre
FMeCAP = Family Medicine electronic Assessment and Curriculum Platform
IT = Information Technology
LMCC= Licentiate of the Medical Council of Canada
LTC = Long Term Care
MRP = Most Responsible Physician
MSO = Medical Staff Office
NICU = Neonatal Intensive Care Unit
OUD = Opioid Use Disorder
PBSG = Practise Based Small Group
PCN = Primary Care Network
PG = Postgraduate
PGY1/2 = Postgrad Year 1/2
PLC = Peter Lougheed Centre
PMH = Patient Medical Home
PPE = Personal Protective Equipment
QA = Quality Assurance
QI = Quality Improvement
RAAPID = Referral, Access, Advice, Placement, Information & Destination
RGH = Rockyview General Hospital
SHC = South Health Campus
SHCFMTC = South Health Campus Family Medicine Teaching Centre
SL = Supportive Living
SRFMTC = Sunridge Family Medicine Teaching Centre
UCalgary = University of Calgary
UG = Undergraduate
UGFM = Undergraduate Family Medicine
UME = Undergraduate Medical Education

DFM Physician Membership



We represent one of the largest clinical Medical Affairs departments in AHS. This high membership with diverse practice environments continues to challenge us to find innovative ways to connect with our membership and engage them in the numerous activities and initiatives occurring in health care delivery. As with other departments, the Department made a number of rapid pivots to manage COVID-19 as well as numerous other priorities like Connect Care and addressing diversity, inclusion and gender equity. We have laid out this report highlighting some of the overall achievements of our clinical sections and academic pillars.

Community Primary Care

Section Chief: Dr. Monica Sargious

The Community Primary Care section of the DFM has 726 physicians privileged to provide varied levels of care to patients within the City of Calgary.

To support the work of the hospital-based discharge coordinators, the DFM has prioritized maintaining the Physician Directory, an online database containing Calgary Zone physician clinical contact information. This database has supported communication between acute care and primary care, including notification of visits to AHS services such as Emergency Department (ED) and Urgent Care visits, and hospital admissions.

Due to the COVID-19 pandemic, the DFM shifted the delivery of the Mackid Symposium to a virtual format, and partnered with Well Doc Alberta to offer a wellness session focused on Affirmation of Professional Calling. The session was well received.

Calgary Zone PCNs

The Calgary Zone PCNs continue the essential work outlined in its zone service plan. An updated zone service plan for 2021 includes previous priorities: developing the Patient's Medical Home (PMH) as the foundation of primary care, supported transitions between healthcare systems for patient continuity, and specialty integration for physicians. Recently the zone has also formally added mental health as a zone priority. The work of the zone is supported by a robust governance structure and dedicated zone supports. Efforts are being made to integrate various provincial initiatives into existing streams of work, such as Community Information Integration/Central Patient Attachment Registry (CII/CPAR), Alberta Surgical Initiative, and Home to Hospital to Home.

of all COVID-19 cases cared for in the community including LTC

The Calgary Zone has developed and executed a zone wide strategy to respond to the pandemic, placing the PMH at its foundation. A mechanism was put in place for all PCNs to receive referrals from various sources (i.e. Public Health) for follow-up of COVID-19 positive patients. PCN clinics/PCN physicians were able to follow-up on over 43,620 positive cases between October 2020 and April 2021, resulting in 96% of all cases in the zone cared for in the community. The Calgary Zone also developed a number of clinical pathways to support COVID management in the community, and also held a number of well-attended and well-received webinars for knowledge translation related to COVID-19, and also mental health.

AHS Primary Care Clinics

Academic Family Medicine Clinics – please refer to the Academic section for details.

Elbow River Healing Lodge (ERHL) provides culturally competent, trauma-informed primary care to their paneled Indigenous Calgarians at the Sheldon Chumir Health Care Centre. Integrating traditional Indigenous wellness approaches in care is a core part of the mandate. The clinic continues to work on ways to better support its clients and has added a number of specialty collaborations in the past year as well as allied health team members to provide a holistic Medical Home for our patients. ERHL will be part of the Connect Care project and is currently focused on maintaining connections and care during the pandemic, acknowledging and supporting the specific needs of Indigenous Calgarians through this unusual time.

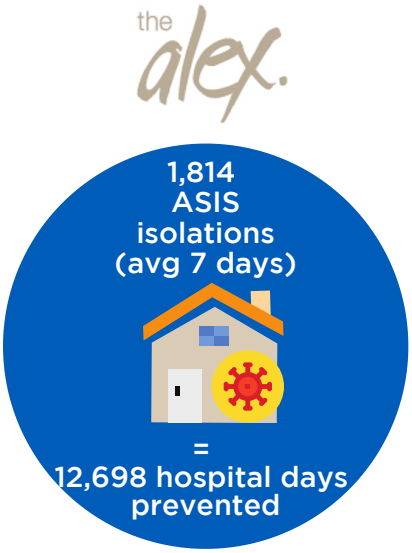
East Calgary Family Care Centre (ECFCC) is a primary care clinic managed by AHS and continues to provide excellent care to patients in the northeast quadrant of Calgary, focusing on complex patients with multiple comorbidities. They are shifting to an ARP this year after a successful application.

ECFCC has also been a key partner in the overall zonal COVID-19 primary care response, working with Calgary Zone PCN leadership to initially model and implement a hub-and-spoke process to manage COVID-19 results and patient follow-up in the zone that has now been expanded across Calgary and surrounding area.

The Alex/Assisted Self Isolate Site (ASIS)

In response to the COVID-19 Pandemic, The Alex partnered with the Government of Alberta, Calgary Homeless Foundation, AHS, and CUPS to form an Assisted Self Isolation Site (ASIS) which opened April 6, 2021 to minimize the impact of COVID-19 for homeless individuals in Calgary. The service is available to anyone who is awaiting swab results, have positive COVID-19 test results or have had direct contact with a known COVID-19 positive individual. The target population is for Calgary and surrounding areas but ASIS has served clients from all areas of Alberta, particularly Indigenous clients from surrounding reserves with 31% of clients identifying as Indigenous.

With no established care model to refer to, the isolation staffing and program model was created. ASIS grew through trial and error and was informed by collaborations Canada wide. A 24-hour healthcare team was established and supported by Family and Emergency Physicians. This team consisted of social supports and case management. The team navigated acute medical and behavioural issues on a daily basis as well as monitoring for COVID-19 related symptoms. As of April 2021, ASIS has hosted 1,814 courses of isolation with an average stay of 7 days which equates to 12,698 hospital days prevented. The highest number of referrals came from shelters (53%) followed by Urgent Care and Acute Care (30%) and Public Health referrals (13%). ASIS clients commonly had Opioid Use Disorder (30%), Methamphetamine Use Disorder (60%), Alcohol Use Disorder (47%) and previously diagnosed mental health disorders (63%). Many clients had multiple comorbidities and unmanaged medical conditions which increased their risk of COVID-19 severity.



The COVID-19 ASIS experience helped create a network of organizations through AHS, City of Calgary, and Government of Alberta which continues to meet weekly to address issues of some of Calgary's most vulnerable residents. As a result they have been able to house a significant number of individuals experiencing homelessness, as well as connect clients to substance treatment programs and reconnect some with their families. The ASIS teams are now focusing on vaccinating their population with outreach vaccination teams.

CUPS Health Highlights

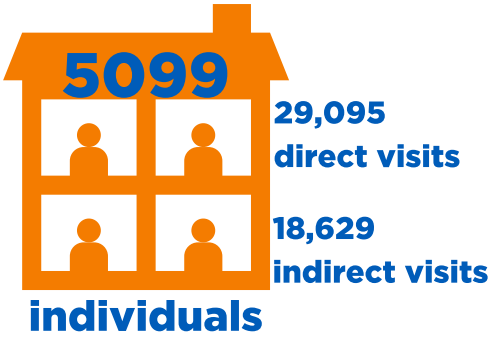
Through integrated programs and services, CUPS supports Calgarians facing the challenges of poverty and trauma to build resilient lives.

2020-21 saw CUPS play a critical role in the COVID-19 response for Calgarians experiencing social vulnerability and homelessness. CUPS was committed to ensuring that those who were at increased risk of infection as well as increased risk of severe COVID-19 disease had access to primary care as well as COVID-19 testing and vaccinations. COVID-19 highlighted the inequities that exist for individuals experiencing homelessness, including challenges in adhering to public health measures, access to safe housing, and increased complications for COVID-19 due to a higher prevalence of co-morbidities.

CUPS increased our services delivered in the shelter system, minimized service delivery disruption at our main site as we shifted to a combined in-person and telehealth model, and implemented numerous enhanced safety measures within the agency. In collaboration with various homeless serving sector partners, stakeholders including the Alex, AHS and Alberta Health, as well as the City of Calgary and the Calgary Homeless Foundation, CUPS played an integral role in the Vulnerable Populations COVID-19 Response Working Group, supported ASIS, and is actively involved in the COVID-19 vaccine rollout for vulnerable populations.

Health Clinic Summary

5,099 individuals accessed services at CUPS for a total of 29,095 direct visits and 18,629 indirect visits.



Maternal Newborn Care

Section Chief: Dr. Norma Spence

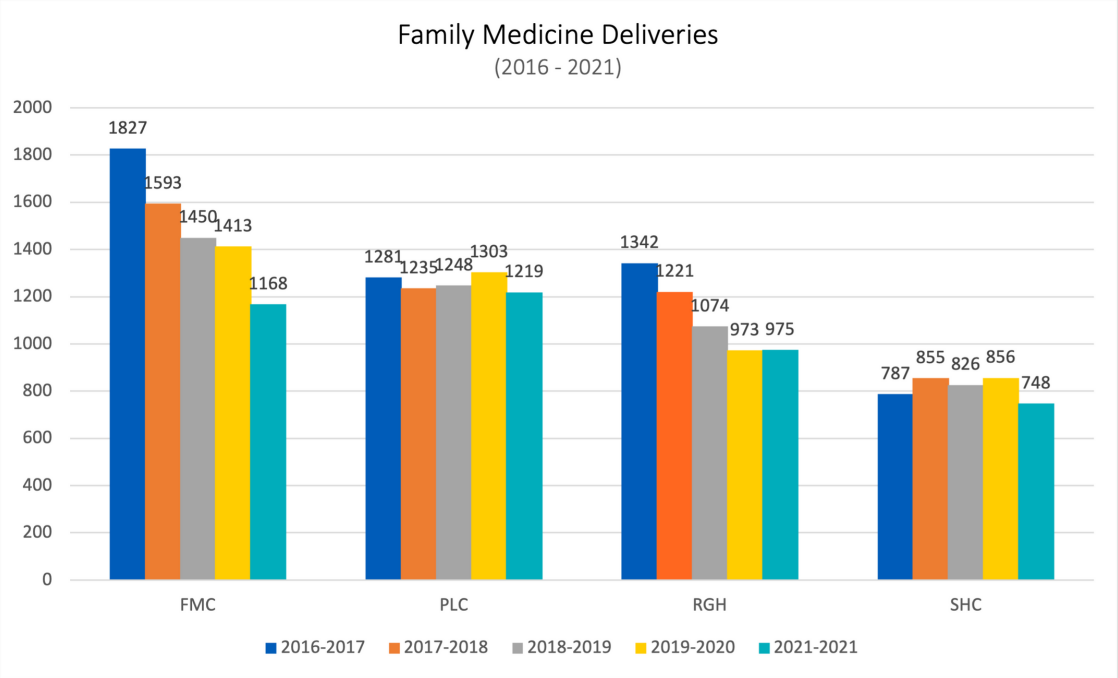
The Maternal Newborn Care section includes 124 physicians privileged to provide obstetrical care at all four of the Calgary Adult Acute Care Sites.

This section works closely with other specialties and professions in their clinical practice, and continues to develop administrative procedures which streamline the service patients receive throughout the continuum of care. Focusing on the prenatal portion of their journey, physicians in this section were involved in creating the AHS Alberta Obstetric Anemia and Iron Deficiency Screening and Treatment Algorithm which has been launched provincially.

With a declining birth rate and lowering referral numbers, physicians within this section are facing a new reality and adjusting the care they provide accordingly.

6575
maternal newborn patients

40.1%
of all admissions for deliveries in Calgary



Physicians in the section have begun seeing their postpartum patients on the labour and delivery units in triage, which has eased some of the patient load in respective EDs and enhanced continuity of care for the patients and their children. Community prenatal offices will also begin offering the pertussis vaccine to pregnant and postpartum women and their families in the office which will increase access for point of care vaccinations.

This collaboration between public health and Family Medicine maternity providers aims to increase the pertussis vaccination rate in this population, a priority for Public Health; however, the main driver is to provide more point of care vaccinations and decrease the need of clients to travel to a different venue for this service

Reviewed literature on frequency of visits during pregnancies and decreased visits based on this literature to minimize exposures for our patients. Virtual care has been essential to the continuation of services in this section.

As part of Labour and Delivery pandemic capacity planning for the Calgary Zone, the South Health Campus Family Maternity Place and NICU moved all obstetrical and newborn care, with the exception of obstetrical outpatient clinics, to the other three adult acute care sites in Calgary, effective April 21, 2020 to June 3, 2020. In total,104 babies were delivered at Rockyview General Hospital (RGH) due to the relocation. In preparation for an increased need for medical inpatient beds, women's health in Calgary has actively been involved in planning and preparing, adjusting the number of delivery and postpartum beds available.

Medical Inpatient Care

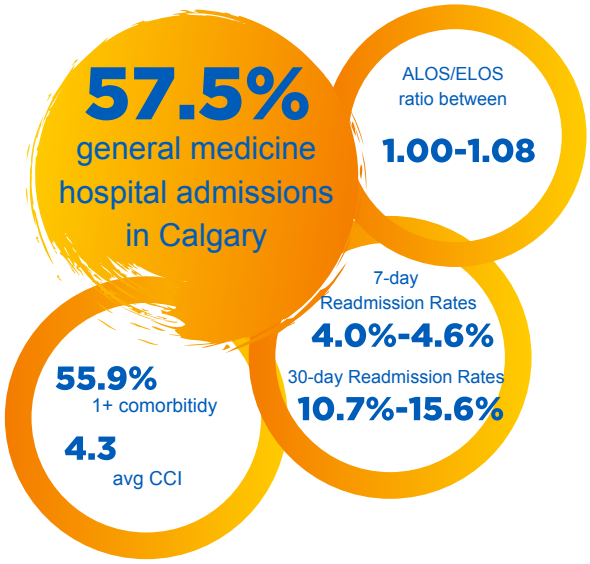
Section Chief: Dr. Jim Eisner/Dr. Marinus Van der Westhuizen

The Medical Inpatient Care section includes 158 physicians privileged to provide inpatient care at all four of the Calgary Adult Acute Care Sites, and various continuing care facilities.

Physicians (hospitalists) in this section have participated in over a dozen QI projects that focus on transitions in care, patient safety, knowledge and skills development, communication, and effective resource utilization. Work continues on improving discharge summaries and all sites have begun transitioning to exclusive digital charting within our current electronic health record and in preparation for the launch of Connect Care. As the eSIM program has expanded to all acute care sites, physicians noted improvements in communication and teamwork as well as increased confidence in managing high acuity complex patients.

Physician Wellness survey showed burnout rates among Calgary hospitalists ranged from 20-49%. The next steps include designing and implementing physician-focused initiatives that address both individual physician and system factors, through which the Hospitalist program can continue to build a culture of wellness.

We saw a transition in section leadership, thanking Dr. Jim Eisner for his many years of dedication and leadership and welcoming Dr. Marinus Van der Westhuizen into the role. In the coming year, the section looks forward to ongoing co-management with medical specialty colleagues to manage primary care needs for specific at-risk populations, and has planned a review of scope of practice to provide greater clarity with respect to care of specific patient populations. Dr Serena Siow was appointed the new deputy section chief in December of 2020.



Urgent Care

Section Chief: Dr. Charles Wong

72,926

urban urgent care presentations

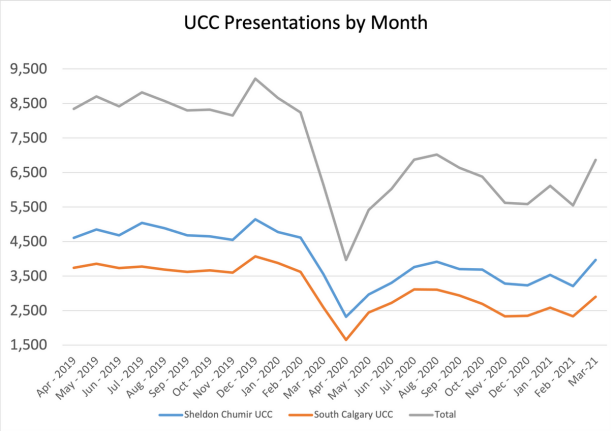
The Urgent Care section includes 61 physicians privileged to provide care to patients with unexpected but non-life-threatening health concerns that require same-day treatment at both the Sheldon M. Chumir Health Centre Urgent Care and the South Calgary Health Centre Urgent Care.

Acuity at both sites increased over the past year and urgent care physicians and allied health staff continued to balance their unique role in the space between primary care and ED care.

With the change in acuity and evolving expectations of patients and system partners, the AHS Urgent Care portfolio conducted a comprehensive internal review to guide the future direction of the Urgent Care Centres (UCC) and inform a Strategic Plan. Both Urban Urgent Care sites have collaborated with key internal and external stakeholders to assess four pillars that are instrumental to the enhancement of service care delivery in Urgent Care Centres. Along with many other sections and departments, the Urgent Care section recognizes the potential of physician burnout and has endorsed the importance of physicians' well-being and the impact it has on patient care delivery and safety, and implemented a physician peer support group, supported by Well Doc Alberta.

The COVID-19 pandemic presented unique challenges and opportunities to the UCCs. Highlighting the front-line importance of the urgent cares is that the first case of COVID-19 in Calgary was detected at the Sheldon Chumir from a returning traveller. The UCCs collaborated closely with the hospital and emergency department systems to ensure that Calgarians had adequate access to life-saving resources in the event of hospital overflow. Airway and resuscitation capabilities were refreshed, including the addition of new GlideScope laryngoscopes. Safety protocols were rigorously implemented, and zero UCC physicians have contracted COVID-19 in the UCC setting to date. As a learning point, the UCCs in fact saw significant declines in low acuity patient volumes that coincided with legislative lockdowns. Rates of non- COVID-19 infectious disease presentations declined significantly as well.

Apart from COVID-19 preparedness and response, one of the biggest challenges in the next year will be the launch of Connect Care in UCCs. While initial preparation was for a May 2020 launch, COVID-19 necessitated a delay with a new target of February 2021, and then further delayed to November 2021.This transition will demand significant attention and person-power over the upcoming six months as we train super users and the physicians and staff they will support.



Palliative Care

Section Chief: Dr. Charlie Chen

The Palliative Care section includes 46 physicians who are privileged to provide palliative/end of life care to patients across all service areas in the Calgary Zone.

As a section, we continue to emphasize the importance for patients to have as much information and control over their palliative and/or end of life experiences that not only include leading palliative care management skills and programs, but also numerous quality and patient experience through these initiatives. These include partnering with the Division of Palliative Medicine on the Palliative Care Early and Systematic (PaCES) project to improve timely palliative care referrals for advanced colorectal cancer patients, and the development of education and promotion sessions on Advance Care Planning/Goals of Care discussions for PCNs.

The Hospice Transition Guideline was developed in collaboration with local hospice site leaders to identify a consistent process for all Calgary Zone hospices to use when managing hospice patients who are transferred home or to a different facility as the most appropriate place for care. A strong commitment to clear communication with patients and families in highlighted. In a similar vein, a major project has been undertaken to refresh urban Palliative Home Care admission criteria, referral documentation, and related processes. This aims to ensure our patients needing this service are cared for in the most timely, efficient, and appropriate ways.

Like all aspects of healthcare, the COVID-19 pandemic impacted the delivery of palliative care in the Calgary Zone in significant ways. The acuity, complexity and volume of patients choosing to be cared for at home (rather than going into acute care or hospice) significantly increased. Adapting quickly to provide virtual consultation in our rural and urban community settings, though not as effective as in-person visits, was still considered to be efficient. Creative solutions were also deployed to assist family and loved ones to virtually visit patients admitted to our Intensive Palliative Care Unit or our hospices.

The section has also formed a working group to discuss issues pertaining to Equity, Diversity and Inclusion. Work has begun to ensure our application and selection processes for consultant physicians and palliative care residents are fair, transparent, and inclusive. Work also continues to examine ways to improve access to palliative care for Indigenous communities and other marginalized groups.

Finally, we eagerly anticipate the opening of the new Cancer Centre and are participating in a design process to develop model(s) of care for the delivery of palliative care in that new setting.

1250 Hospice Admissions

5078 Palliative Care Consult Team Patients Seen

1257 Palliative Home Care New Referrals

512 Intensive Care Palliative Unit Admissions

102 Virtual (Zoom) Consultation Visits by the Rural Consultation Team

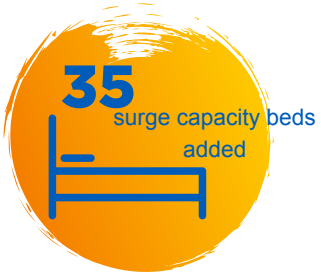
Seniors Care

Section Chief: Dr. Vivian Ewa

The Seniors Care section includes 311 physicians who work in multiple areas across the continuum of older adult care, from home living to Long Term Care (LTC) providing care to older adults within Calgary.

Seniors care physicians have been caring for and treating their patients at their place of residence (home or facility) where appropriate during the COVID-19 pandemic. This has minimized ED visits for this patient population, which in turn has increased the physician support required.

Even prior to the advent of the pandemic, the Seniors Care section had made strong gains in home-based primary care services. As the proportion of seniors in Alberta grows, higher numbers of clients require home visits due to various limitations on their mobility and ability to access health care and health care programs. We are working with local PCN partners to improve integration of care, and developing programs with stakeholders to reduce acute care admissions.



Physicians in this section are involved in a number of quality improvement initiatives, including a project called Collaboration Leading to Expedited Admission and Return to LTC (CLEAR LTC), which has resulted in an 11% reduction in length of stay for LTC patients in acute care sites, and the development of a process that facilitates patient safety conversations between residents, families and health care providers in long term care to reduce communication gaps.

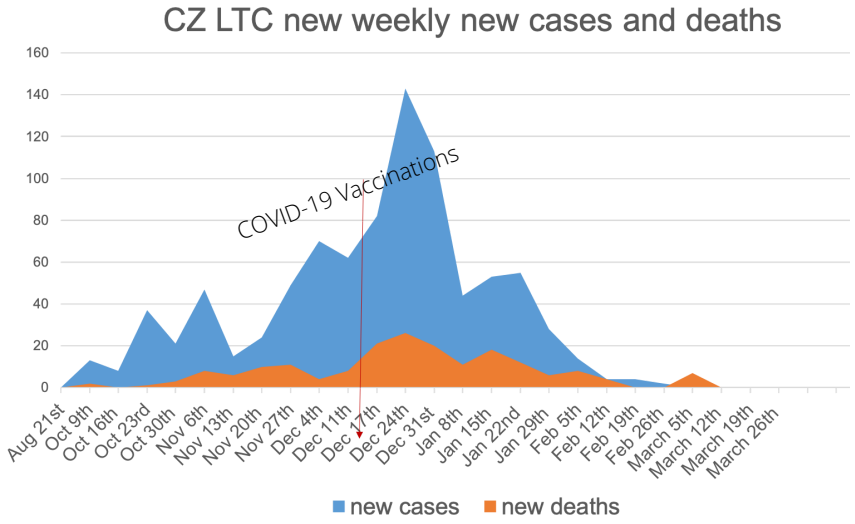
The ongoing (Referral, Access, Advice, Placement, Information & Destination) RAAPID ED LTC project has spread beyond Calgary Zone to the Central zone. The success of this project in reducing avoidable transfers to ED from LTC was felt during the pandemic with only 1.4% of COVID-19 cases in LTC transferred to ED. RAAPID also facilitates discussions between ED and LTC physician to optimize transfer if required and reduced length of stay in ED. Connection with specialist on-call is also facilitated by RAAPID.

McKenzie Towne LTC, one of the first facilities in Alberta to declare an outbreak of COVID-19, had to act quickly to develop a medical pathway for continuing care which has since been adopted provincially and continues to be utilized.

The Carewest Colonel Belcher Veterans Care centre opened a new 29 bed complex mental health unit. These beds opened to address capacity challenges in acute care for persons with complex mental health diagnosis waiting for LTC spaces in partnership between family physicians and psychiatrist on the unit.

Finally, the section continues to work on an Alternative Relationship Plan (ARP) to support the variety of programs in the section that struggle under the fee for service system. This is a challenging time for ARP development and significant time and effort continue to be applied to this joint Geriatrics – Family Medicine clinical ARP application.

The impact of COVID-19 vaccination of residents and staff which started on December 16, 2020 can be seen in the significant decline in cases and deaths in LTC. Family physicians practising in these settings played a key role in ensuring their residents and caregivers had the right information on COVID vaccines and consented to being vaccinated. Physicians also participated in campaigns to address vaccine hesitancy amongst frontline staff in LTC.



Clinical/Medical Operations

Deputy Department Head; Director, PMH & QI: Dr. Maeve O'Beirne

Medical Director, Academic Teaching Sites: Dr. Melanie Hnatiuk

48 physicians across three sites care for over 27,000 panelled patients in the Patient Medical Home model. The PMH allows for patient-centred, accessible, adaptable, comprehensive, coordinated, and continuous care in a trusted team(1). This model has been particularly important during the COVID-19 pandemic in order to support vulnerable patients and those with chronic medical conditions in the community, as well as provide care to patients diagnosed with COVID-19 to minimize the likelihood of presentation to acute care. Our sites have remained open and available to patients for both in-person and virtual care throughout the COVID-19 pandemic. Figure 1 depicts our patient numbers. Figure 2 demonstrates the adaptation of the medical home from all in-person visits to a mix of virtual and in-person visits (% of total visits).

Figure 1

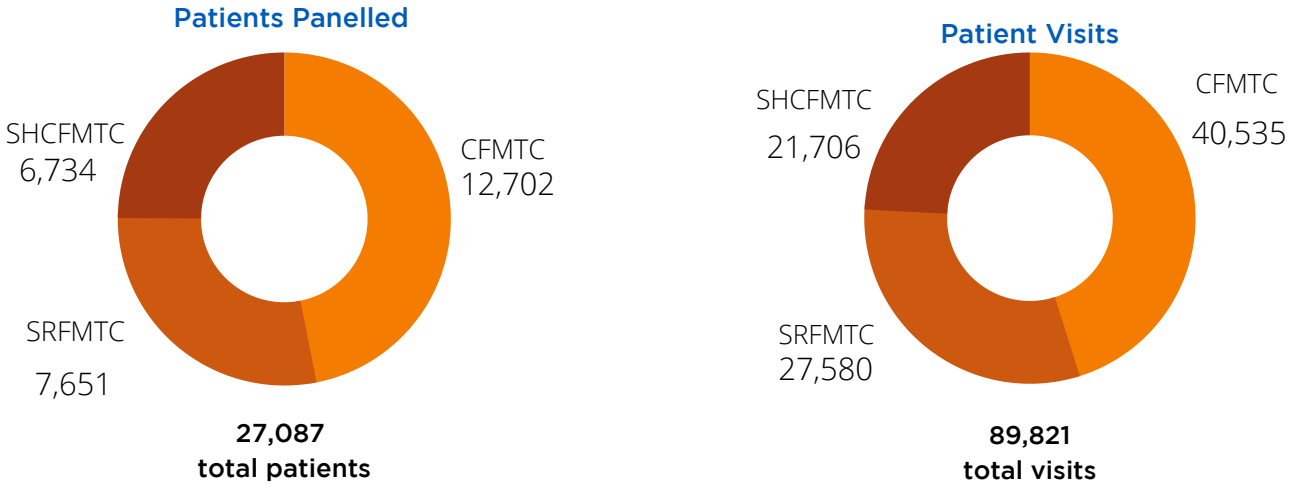
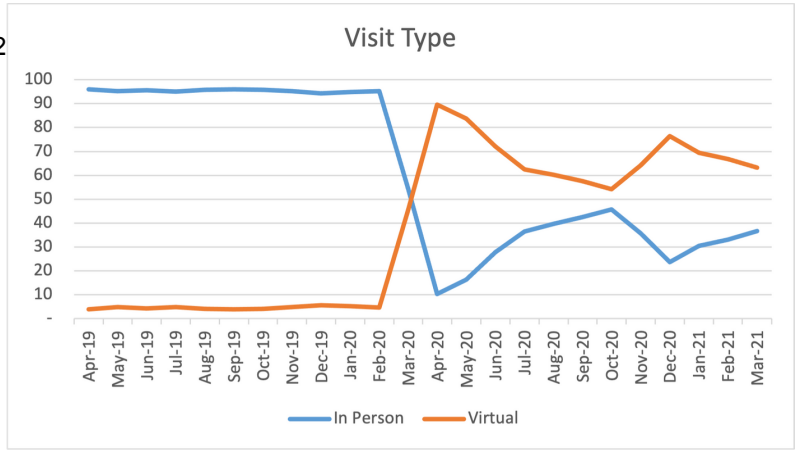


Figure 2

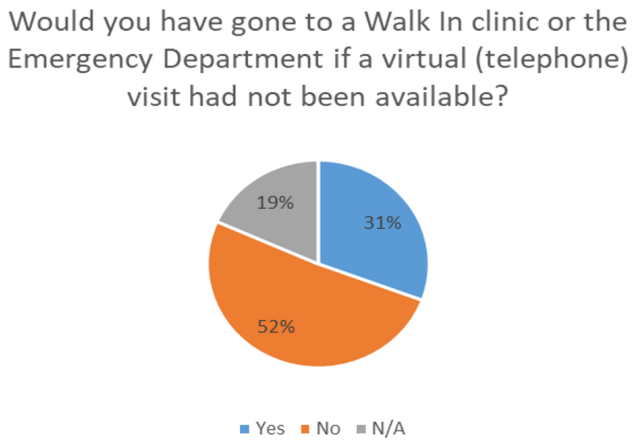


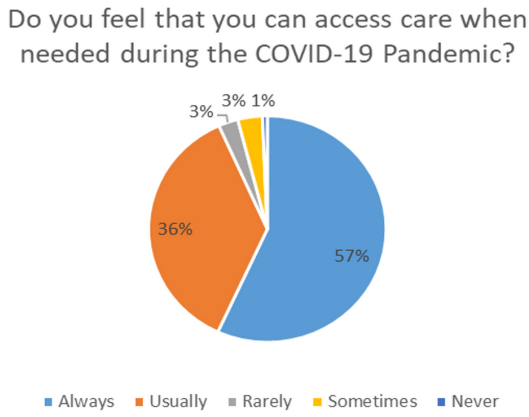
(1) https://patientsmedicalhome.ca/files/uploads/PMH_VISION2019_ENG_WEB_2.pdf

COVID-19 Care in the PMH

The Calgary Zone pathways for patients with presumed or confirmed COVID-19 infections are used to guide care in the community. Through partnerships with local PCNs, our teams received the information on COVID-19 positive patients to allow for care in their medical homes. The DFM has cared for 978 COVID-19 patients through 714 COVID-19 pathway calls, 133 of which occurred outside of regular clinic hours.

A team-based approach was used to support the patient, provide teaching, and optimize care in the medical home during the pandemic. Patients were contacted as soon as a COVID-19 positive result was received to provide information regarding isolation, risk stratification and management. Each site developed an appropriate workflow, involving the multidisciplinary team in collaboration with physicians to contact patients on the COVID-19 pathway, often daily, as appropriate for their risk level.

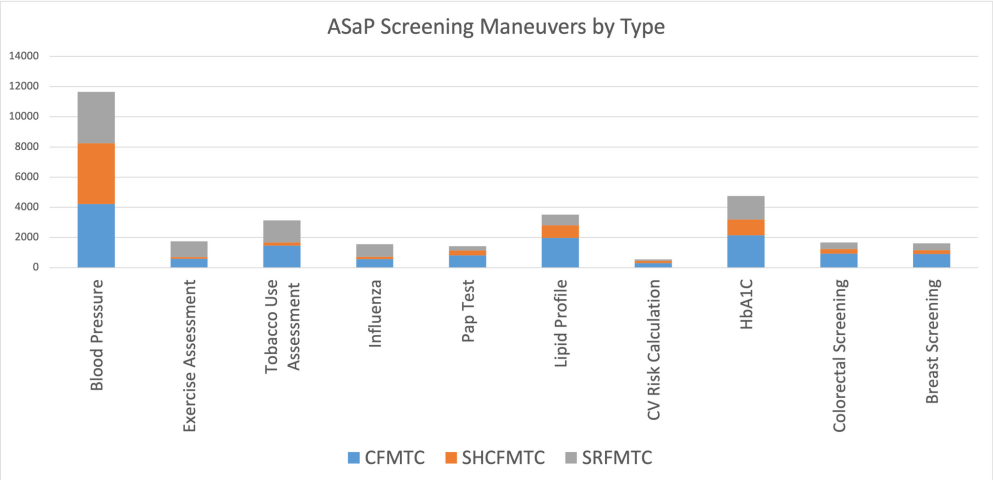




COVID-19 Patient Outreach

The clinic teams quickly responded to changing needs of patients during the COVID-19 pandemic by further increasing patient outreach. In the early phase of the pandemic, physicians identified the most vulnerable patients in their respective panels and the clinic teams reached out to these patients individually to ensure they were safe and supported as restrictions and health needs evolved. It was also an opportunity to initiate conversation and provide resources on goals of care and personal directives.

As the pandemic evolved, all sites continued to provide regular primary care as appropriate to their panelled patients, including discussions with patients regarding appropriate screening investigations as per the Alberta Screening and Prevention Program (ASaP).



COVID-19 Vaccination

As vaccination rollout progressed in Alberta, our teams were able to utilize our Electronic Medical Record (EMR) to create lists of panelled patients who qualified in the appropriate vaccination phases. Physicians and site teams identified patients who may have vaccine hesitancy or require additional support to book vaccination, and contacted those patients. In preparation for Phase 2B and potential delivery of vaccination, the expertise of the Informatics Team was leveraged to prepare EMR/database searches based on underlying medical conditions and create lists of panelled patients for physicians to review.

Community Information Integration/Central Patient Attachment Registry (CII/CPAR)

All three sites are now live on CII/CPAR, and are managing both demographic mismatches and provider conflicts, which are done using both opportunistic and outreach processes, as well as sending information to Netcare via the Clinical Encounter Digest, and receiving e-notifications. This serves to strengthen provider and informational continuity within the PMH and the community, which has been shown to improve patient outcomes and decrease system costs(2). Times of transition for patients are particularly important for informational continuity and CII/CPAR is one mechanism to support informational continuity to the medical home at these high-risk times.

Team-Based Virtual Care - Group Education

Members of the South Health Campus clinic team were involved in creating a six-week education session for patients with diabetes. With the COVID-19 pandemic, the team was able to transition this workshop to a virtual environment and deliver it to patients from within the medical home. The format enabled patients managing their chronic disease to interact with each other and with members of the medical home team in a safe and structured setting, during a time of many unknowns early in the pandemic. In post-workshop feedback, respondents strongly agreed that the sessions were interactive and the delivery system was effective. They also strongly agreed to learning new and relevant information that can improve self-management.

Average HbA1C results 6 months after the diabetes workshop showed a reduction in the diabetes group participants of 0.93%, compared with provincial Canadian Primary Care Sentinel Surveillance Network (CPCSSN) data showing the average HbA1C to be consistent over the same time period, and with local PCN data showing an increase of 0.1% over the same period.

One participant stated:
“The team has guided me through a positive health journey that has literally changed and saved my life. The health team has supported my choices and has offered me plans to continue health wellness. Most recently, I got to experience a 12-session wellness diabetes virtual seminar. The program easily educated me on all aspects of my diabetic condition. The group involvement made the seminar comfortable on subjects that are not easily talked about. I look forward to continuing my care through a health home that has my back always”.

With the success of this virtual format, another group-based patient education initiative, the Anxiety to Calm workshop, was adapted and delivered virtually.

In late March 2021, the clinic, supported by our social worker, offered a virtual group health and wellness session to our patient population, particularly those struggling with coping or at risk of social isolation during the pandemic.

(2) https://patientsmedicalhome.ca/files/uploads/PMH_VISION2019_ENG_WEB_2.pdf

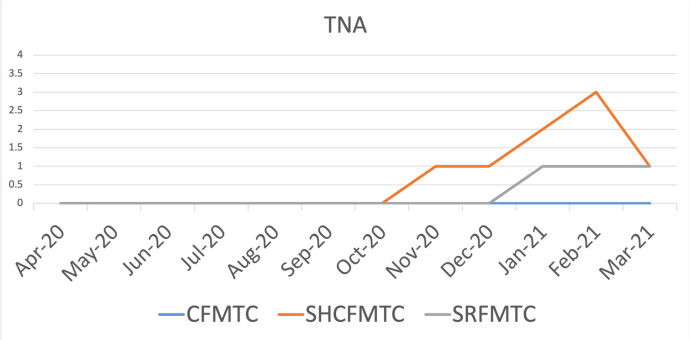
After Hours Care

Patients with chronic conditions, or those who had required frequent emergency care were identified by their physicians and care teams to receive care through the MD24 system where panelled patients could contact Health Link and be connected to an on call physician, ensuring care for these patients was provided 24 hours a day, 7 days a week.

In addition, after hours care was expanded to include evening clinics at all sites in order to improve access and continuity for patients.

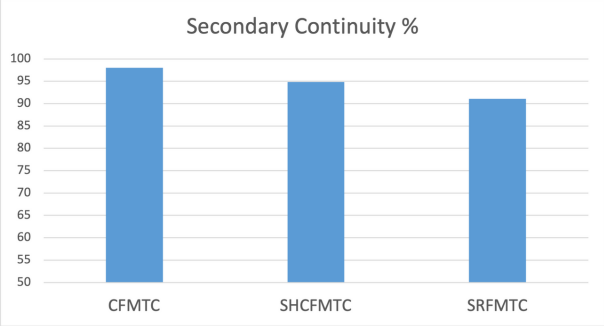
Accessible Care - Time to Next Available (TNA)

TNA measures the ability of a patient to see their physician in a timely manner and is one metric used to demonstrate accessible care. The TNA data for each of the academic teaching centres is demonstrated in the graph below.



Continuity

Secondary continuity of care in the DFM is defined as the percentage of time a patient is seen by a physician in their home base/paneled microsystem and is depicted below for each of the academic teaching centres.



Education

Director, Postgraduate Education: Dr. Lindsay Jantzie
Director, Undergraduate Education: Dr. Martina Kelly
Education Manager: Mr. Craig Cutler

Undergraduate Education

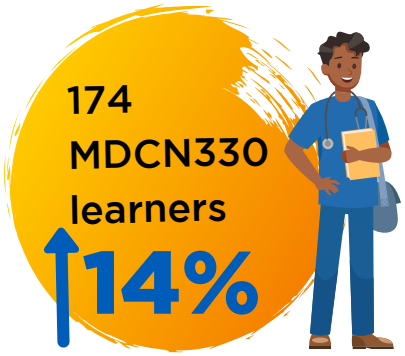
In January 2020, the Undergraduate Family Medicine (UGFM) team launched the new Clerkship 4+4 curriculum (four weeks urban and four weeks rural), realizing the hard work of our Clerkship Leadership team. Unfortunately, with the onset of COVID-19, all students were pulled from clinical activities and our entire team had to pivot to meet the demands of a new virtual curriculum.

Within the span of a month the clerkship academics curriculum was revised and delivered via Zoom, providing engaging academic activities ranging from didactic lectures to interactive online cases developed in-house. When students were able to return to clinical activities, the schedule was condensed to enable graduation. The family medicine curriculum was shortened back to six weeks, and our goal of having every student experience four weeks of urban clerkship and four weeks of rural clerkship was no longer possible for the classes of 2021 or 2022. Despite the setbacks, the 4+4 curriculum will be re-introduced for the class of 2023. Simultaneously, the MDCN 430 clinical experiences were replaced by virtual panel sessions and small group case discussion.

In the spring, when students were allowed to return to clinical activities, clerkship placements were quickly rescheduled and the UGFM team was able to provide an excellent variety of urban and rural community clinical experiences, thanks to our dedicated preceptors. The UGFM team took the lead on securing and distributing Personal Protective Equipment (PPE) to clerks, removing the additional financial burden from community preceptors while keeping students safe until Undergraduate Medical Education (UME) could establish a permanent solution.

Unfortunately, UGFM was not able to offer the new class of medical students the popular Med Zero experience in July 2020, a significant loss for the student body as well as to our goal of promoting family medicine. In an effort to make up for this, the class of 2023 were welcomed to the MDCN 330 clinical experience with a week-long virtual onboarding. The class of 2023 expanded to 174 students, a 14% increase from the past year, resulting in a push to recruit additional clinical capacity. The UGFM leadership managed to recruit 60 new preceptors to meet this demand.

The Family & Rural Medicine Interest Group largely had to postpone their usual events due to COVID-19. They were able to continue to engage the students and have successfully adapted their sessions to a virtual setting, utilizing social media to raise awareness and promote family medicine.



Postgraduate Education

In the midst of the COVID-19 pandemic, the residency program welcomed 92 first year residents in July 2020, while continuing to train over 100 second year and Enanced Skills (ES) residents. In total, the DFM trained 218 residents across 10 programs.

Program faculty and staff continued to implement recommendations from our last accreditation cycle, as well as prepare for and brainstorm innovations that will contribute to the upcoming 2022 accreditation.

COVID-19 impacted several learning experiences, especially in the core 2-year family medicine programs. Program faculty and administration worked diligently to adapt curricular experiences, reschedule residents, and accommodate preceptors whose clinical environments changed as a result of the pandemic's impact. All in-person academic sessions transitioned to virtual events for the duration of the academic year (including conferences, scholarship day, weekly and monthly academics, and the Post-Grad Year 1 July orientation), to comply with public health restrictions and ensure the safety of our residents. Calgary and rural residents have continued to volunteer for redeployment to the Intensive Care Unit to assist this service and its workforce through each wave of the pandemic.

Resident resiliency and well-being was identified as a critical issue throughout COVID-19. The program established a Resident Wellbeing Advocacy Committee at the end of 2020. The main purpose of this committee is to collaboratively communicate, assess, and advocate for the needs of the residents in promoting well-being. There has been ongoing work to align the Calgary and Rural Programs, which was a recommendation of the 2018-2019 Organization Review Project. The Residency Program Committee continues to run as a single committee for the core 2-year programs, which has resulted in improved communication across all divisions and sites.

The Calgary core 2-year program will undergo further curriculum changes in July 2021, which were approved by the Curriculum and Evaluation Committee in spring 2021. Many of these changes were driven by the last external review, in addition to feedback from several past residents and preceptors. These changes include increased early exposure to family medicine home clinics in the first month of residency, enhanced psychiatry training experiences in acute, outpatient and community environments, and increased learning experiences in internal medicine, addition medicine, and Indigenous Health.

The Rural Program will not undergo any significant curriculum changes in 2021-2022. Ongoing care and attention will be put towards supporting rural family medicine preceptors and teams participating in the 24-week Family Medicine Post-Grad Year 2 rotation, a hallmark of the rural program's curriculum. In addition, the program leadership team will continue to explore ways to enhance rural residents' clinical experiences with adults experiencing addiction and/or concurrent disorders, their competencies related to caring for Indigenous people in southern Alberta, and increased opportunities for residents to develop their own teaching skills.

The residency program managed the cancellations of the Licentiate of the Medical Council of Canada exam Part 2 in the fall of 2020 and winter 2021. Residents will write this exam in a virtual format beginning in May 2021. Residents wrote the adapted fall 2020 and spring 2021 Certification in College of Family Physicians (CCFP) examinations (without the subjective office oral exam) in a virtual format.
The core 2-year program delivered a completely virtual CaRMS promotion and selection process in 2021, in accordance with new pandemic timelines and rules implemented by the Association of Faculties of Medicine of Canada. Recruitment events ran from November 2020 through March 2021 for both the Calgary and Rural Programs.

In March 2021, the Calgary Program and Rural Program virtually met and interviewed over 590 and 200 first-round candidates respectively.

Electronic Assessment and Curriculum Mapping

Considerable effort was made to map the CFPC's 99 priority topics and 900+ key features to the program's 26 Entrustable Professional Activities (EPAs) in 2019-2020, providing the foundation of the new Family Medicine electronic Curriculum and Assessment Platform system (FMeCAP). New mapping work in 2021 is underway to include the CFPC's 6 new priority topics/key features, the updated mental health key features, the rural and remote priority topics/key features, and the new CanMEDS-Family Medicine Indigenous Health supplement. FMeCAP was piloted in July 2020 to a small number of residents and preceptors and rolled out officially in November 2020 to all core 2-year program residents, in addition to the palliative care and care of the elderly enhanced skills residents. Postgraduate leadership and administrators have been working hard to enable online daily field note data collection, online progress reviews, one-stop ITER collection, linkages between assessment and curriculum hierarchies, and basic program evaluation functionality.

Enhanced Skills (ES)

The eight ES programs have been transitioning to competency-based medical education (CMBE). CBME is a national and local priority for ES programs. All ES programs in the DFM are developing EPAs and the DFM is a national leader in this area. Once the EPAs for each ES program are complete, a curriculum development and a curriculum mapping process will follow.

Continuing Professional Development

Over the past year, there have been 8 CPD events with over 180 participants. COVID-19 has made providing some CPD sessions difficult, however the team was able to create a robust Grand Rounds curriculum and successfully transition our annual Fall Together to a virtual half-day conference, with one attendee commenting 'Best Fall Together ever'. The virtual setting allowed more faculty to attend and participate in the sessions throughout the year, something we look to carry forward post-pandemic.

Research and Scholarly Activity

Scholarship Director: Dr. Turin Chowdhury
Research Manager: Ms. Agnes Dallison

The DFM has four research pillars:

- Indigenous Health
- Health Services
- Health Equity
- Medical Education

Faculty and physicians with academic appointments in the DFM are credited with:

Total Grant Amount Awarded (new money): **$7,970,467**

Total Amount Awarded this Fiscal Year with DFM Primary Investigator: **$1,147,569**

There were 11 COVID-19 grants awarded in the following research pillars: Indigenous Health, Health Equity, and Health Services.

Using A New Methodology to Calculate Primary Care Physician Supply in Alberta and Ontario – Dr. Terrence McDonald (co-investigators Brendan Cord Lethebe, MSc, Lee A. Green, MD MPH)

CMAJ Open publication

This study was designed to enhance our understanding of the supply of family physicians based on the service activity they provide, and introduces a new method to calculate primary care physician supply.

Having an accurate count of family physicians is an important component to meeting the health needs of people in Alberta. In Canada, physician numbers are derived from head counts and estimates of full-time equivalents based on income percentiles, it assumes each full-time provider provides the same amount of service. The new service day method classifies physicians as full-time if they provide three or more service days per week and part-time if they provide fewer than three service days per week. Both full-time and part-time are based on a 46-week period. A service day is defined as 10 or more patient visits valued at $25 or more billed on one calendar day.

In this study, the researchers used an observational design and provincial physician claims data (2011-15) and compared two methods to calculate the number of part-time and full-time family physicians by the income percentiles method from the Canadian Institute of Health Information and the new service day activity method. Physician and practice characteristics were then described and included annual billings, level of patient continuity, the number of service days worked and patients seen.

The results of the study determined that the two methods agreed upon approximately 85% of Fee-for-Service GPs in 2015, but disagreed on 490 GPs. The income percentiles methods classified 239 family physicians as full-time, but were part-time by the service day method. This particular group of physicians worked less, billed more and saw higher numbers of patients, but provided much less continuity than their colleagues. These differences identified by the service day method have important implications when considering physician supply policies. By highlighting practice pattern differences that the older method does not, the service day methodology provides an enhanced view of primary care physician supply in Canada.

Funding for this study was provided by the Departments of Family Medicine of the University of Calgary and the University of Alberta and by a grant from the M.S.I. Foundation in Alberta. The authors extend sincere thanks to Dr. Richard H. Glazier for his valuable input on the relevance and applicability of the service day methodology and to Dr. Diane Lorenzetti for her assistance with the literature review supporting this project.

Since this study was published, the service day methodology project has been funded and the method re-applied to calculate family physician supply in both Ontario and Alberta by Dr. Glazier and his team from the Institute of Clinical and Evaluative Sciences. Dr. McDonald continues to lead this multi-province supply project that aims to explore family physician supply numbers and service day provision. Publications on this longitudinal analysis 2005-19 are expected in late summer 2021.

UNIVERSITY OF CALGARY

Alberta Health Services

Thank you for reading.

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