

2019 ANNUAL REPORT

MAKING CONNECTIONS:
THE ROOTS OF FAMILY MEDICINE

DEPARTMENT OF
FAMILY MEDICINE



UNIVERSITY OF
CALGARY



Alberta Health
Services

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

Unless otherwise stated, the work presented within this report occurred between April 1, 2018 and March 31, 2019.



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INTRODUCTION

Building relationships with patients and families is the core of Family Medicine, allowing us to connect with them in a unique way to promote and develop healthy lives. The Department strives to support members in their medical homes or as part of the family medicine medical neighbourhood in connecting broadly with partners and stakeholders to promote and enhance a robust, prominent, and active primary care community essential to a high-performing health care system.

Our department represents a diverse community of physicians and allied health teams, with a footprint and impact in every arm of health care delivery; from research and teaching, to inpatient care, medical homes in the community and within Alberta Health Services, to end of life care and urgent and emergent health needs. In this report we hope to showcase the deep roots Calgary Family Medicine has in our system and the strong connections that have positioned our profession and its partners to face the challenges and needs ahead.

We hope you read on for more detail on the incredible work our family physicians, teams, and leaders are doing in the Calgary Zone. We look forward to working with patients, families, and other stakeholders as we continue to deepen our roots and broaden our connections.

Dr. Charles Leduc
Academic Department Head

Dr. Michael Spady
Clinical Department Head

Dr. Sonya Lee
Deputy Academic Department Head

Dr. Ann Vaidya
Deputy Clinical Department Head



EXECUTIVE SUMMARY



EXECUTIVE SUMMARY

The Calgary Department of Family Medicine (DFM) membership reached 1247 medical staff appointed members in 2018, with 1094 academic appointments within the University of Calgary. The DFM represents a diverse physician membership in backgrounds, skill sets, and focus, with a neutral gender ratio and a strong presence in both acute and community care settings.

With a clinical arm consisting of six sections and an academic arm that focuses on research, teaching, and development of best practice in primary care delivery, the focus is broad but rooted in making strong connections between the teams, allowing a continued focus on quality, safety, improved patient experience, and developing medical homes as priorities for department leadership and members.

A sustainable health care system includes more care in the community in the future, with safer transitions in and out of acute care. The Medical Inpatient Care section continues to focus on, and excel in, the management of complex hospital admissions and safe transitions back to community medical homes (page 23). The section of Maternal Newborn Care maintains a strong and collaborative presence in all four adult acute care sites and continues to drive multiple quality initiatives (page 25). With increasing pressures on Calgary Zone emergency departments, the physicians in the Urgent Care section are seeing increasingly complex issues (page 31) and are looking to the development of a strategic plan in the year ahead to help define how to best serve patients in a balanced way, adjusting to the needs of acute care, emergency departments, primary care networks (PCNs), and community physicians.

Both the Seniors Care and Palliative Care sections work in the challenging environment where patients and their families must navigate the intersections of acute, facility, and community care settings. With an increasing number of long term care and supportive living beds (page 35), innovative approaches to support Calgary area seniors are increasingly important and a main focus of the Seniors Care section leaders and members (page 37). Similarly, end of life care continues to evolve and grow in complexity with the Palliative Care section working hard to leverage strong primary care connections (page 34) and support patients at home, in hospice, and in hospital (page 28).

The DFM's Community Primary Care section is the largest and most diverse, with members providing care in community settings enhanced by PCNs, and in areas of special needs including indigenous, LGBTQ2+, and refugee populations (page 20). The Community Coalition (page 21) has provided a highly regarded venue for information and experience sharing, where novel and innovative actions spread and new ideas develop. The DFM partners with the Zone PCN Committee and together form a strong and cohesive group for primary care collaboration, innovation and excellence, adapting and thriving under an enhanced provincial and zonal governance structure. Specialty Integration (page 24), the Mental Health and Opioid Response (page 22), Supported Transitions (page 23) and Medical Home Development (page 22) working groups remain active hubs of innovation and progress.



The Cumming School of Medicine's Department of Family Medicine continues its growth in research. The last year saw an influx of almost seven million dollars in grants and the department houses an increasing number of students and aspiring researchers in primary care and family medicine. Dissemination of results continues to be a successful enterprise as members have published 96 peer-reviewed papers and presented more than 200 times at refereed conferences.

The Department counts on an Alberta-wide group of more than 1000 clinical preceptors, supporting learners in undergraduate and residency programs. The three academic teaching clinics provide care to over 51,000 patients and support over 220 learners through the postgraduate program. The Department is actively defining the foundations of the academic patient medical home and is benefiting from all of the innovations member clinicians develop

in their communities. Through quality improvement initiatives that focus on complex patients, health equity, and collaboration with other units, the academic DFM is forming new connections and consistently affecting change and evolution of care systems.

In an environment of constant change, the DFM continues to look for opportunities to engage with partners and understand the role of primary care in a high-functioning health system. This year, physician and operational leaders participated in a full day retreat on Truth and Reconciliation through Right Relations at the Banff Centre, expanding knowledge on the challenges faced by indigenous Albertans and the common goals shared with indigenous partners in health care planning (page 10). Continuous leadership development and progressive approaches to health care delivery in Calgary and Alberta as a whole are highlighted in the detailed report.

HIGHLIGHTS

NUMBER OF PHYSICIANS WHO HOLD MEDICAL STAFF APPOINTMENTS IN THE CALGARY DEPARTMENT OF FAMILY MEDICINE	1247
PERCENTAGE OF LABOUR AND DELIVERY ADMISSIONS TO CALGARY HOSPITALS BY FAMILY PHYSICIANS	43
PERCENTAGE OF MEDICAL ADMISSIONS TO CALGARY HOSPITALS BY FAMILY PHYSICIANS (HOSPITALISTS)	61
NUMBER OF PATIENT ENCOUNTERS IN CALGARY URGENT CARE CENTRES	99,088
NUMBER OF NEW REFERRALS TO PALLIATIVE HOME CARE	1,273
NUMBER OF NEW CONTINUING CARE BEDS IN CALGARY	732
NUMBER OF TOTAL CONTINUING CARE BEDS IN CALGARY	8,594
NUMBER OF PATIENTS MANAGED IN PRIMARY CARE INSTEAD OF REFERRED FOR SPECIALIST CONSULTATIONS DUE TO SPECIALIST LINK	2,898
NUMBER OF PATIENTS MANAGED IN PRIMARY CARE INSTEAD OF A CALGARY ED DUE TO THE UTILIZATION OF SPECIALIST LINK	1,159
PERCENTAGE OF CALGARY ZONE FAMILY PHYSICIANS WHO HAVE HEARD ABOUT SPECIALIST LINK	89
PERCENTAGE OF CALGARY ZONE FAMILY PHYSICIANS WHO UTILIZE SPECIALIST LINK IN THEIR CLINICAL PRACTICE	72
NUMBER OF PHYSICIANS WITH AN ACADEMIC APPOINTMENT TO THE UNIVERSITY OF CALGARY	1,094
NUMBER OF PATIENTS PANELED TO DFM'S THREE ACADEMIC TEACHING CLINICS	29,054
NUMBER OF PATIENT VISITS AT DFM'S THREE ACADEMIC TEACHING CLINICS	51,341
PERCENTAGE OF PATIENT SURVEY RESPONDENTS WHO RATED THE CENTRAL TEACHING CLINIC AS 'VERY GOOD' OR 'EXCELLENT'	95
NUMBER OF ACADEMIC PUBLICATIONS	96
NUMBER OF ACADEMIC PRESENTATIONS	113
AMOUNT OF GRANT FUNDS RECEIVED	\$6,951,838
NUMBER OF TOTAL FAMILY MEDICINE RESIDENTS	223
NUMBER OF CALGARY PROGRAM RESIDENTS	172
NUMBER OF RURAL PROGRAM RESIDENTS	35
NUMBER OF ENHANCED SKILLS PROGRAM RESIDENTS	16

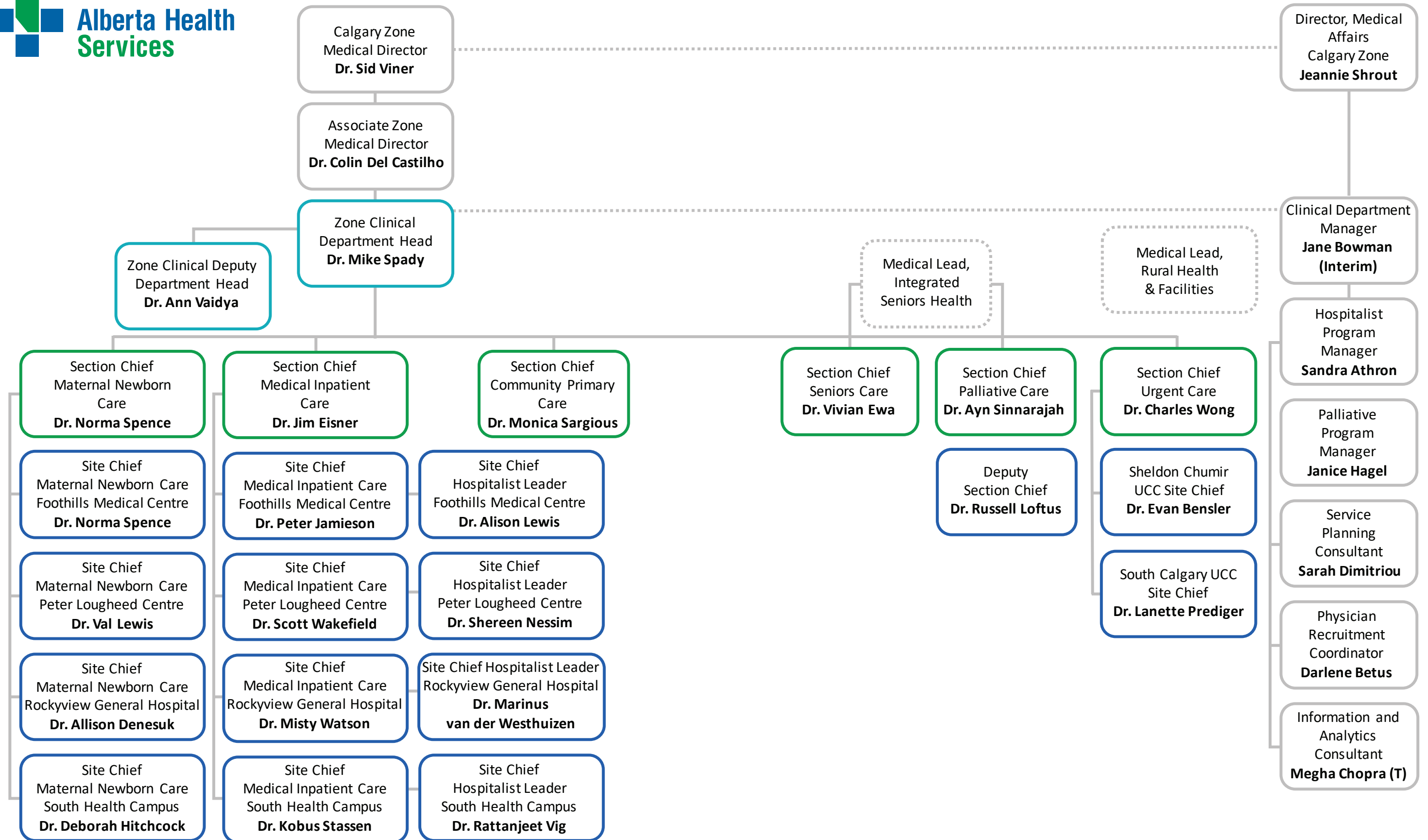


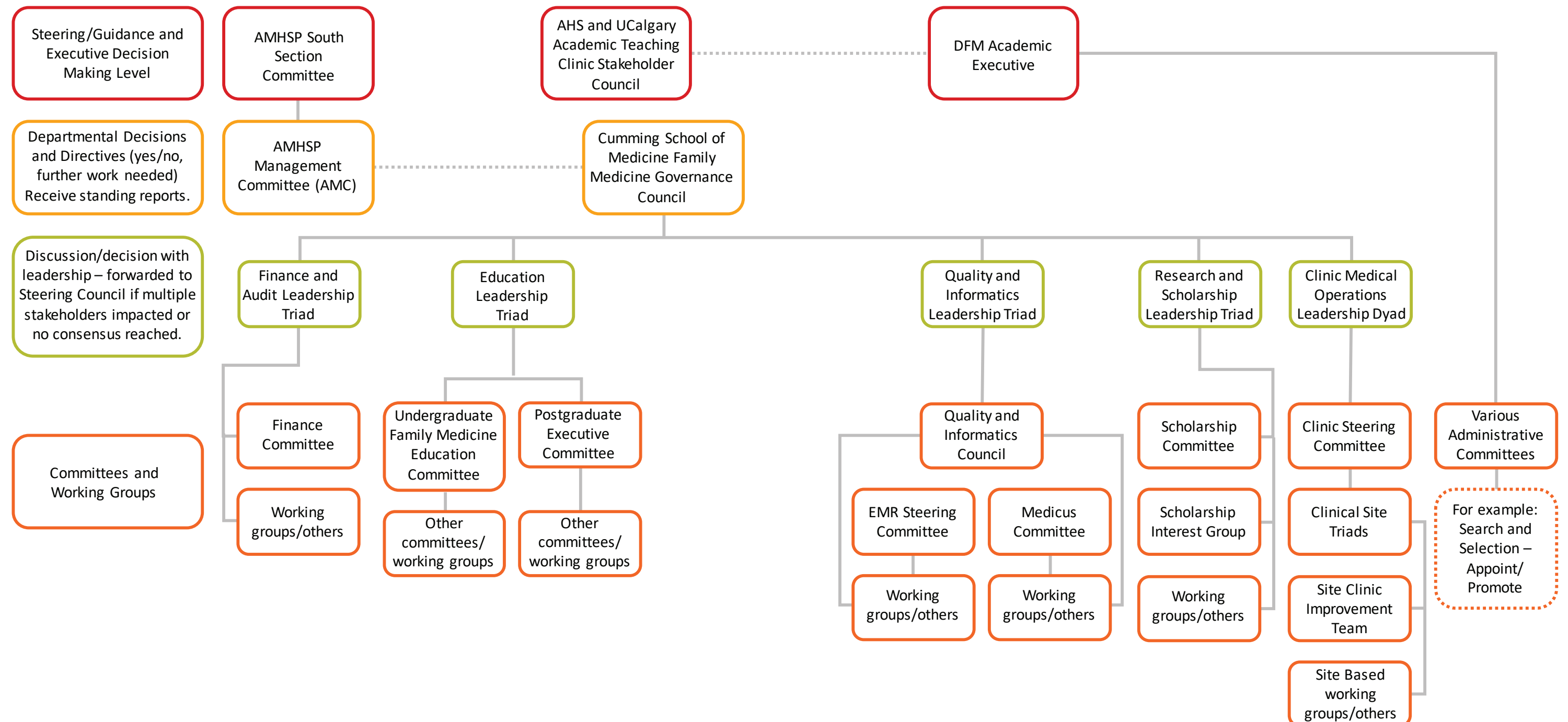
Clinical Department of Family Medicine Executive Committee

- Dr. Michael Spady - Clinical Department Head
- Dr. Ann Vaidya - Deputy Clinical Department Head
- Dr. Charles Leduc - Academic Department Head
- Ms. Allison Mirotchnik - Department Manager (LOA)
- Ms. Jane Bowman - Department Manager (interim)
- Dr. Norma Spence - Section Chief, Maternal Newborn Care
- Dr. Jim Eisner - Section Chief, Medical Inpatient Care
- Dr. Matthew Hall - Section Chief, Urgent Care (vacated December 2018)
- Dr. Charles Wong - Section Chief, Urgent Care (beginning March 2019)
- Dr. Aynharan Sinnarajah - Section Chief, Palliative Care
- Dr. Vivian Ewa - Section Chief, Seniors Care
- Dr. Monica Sargious - Section Chief, Community Primary Care
- Ms. Sandra Athron - Hospitalist Program Manager
- Ms. Janice Hagel - Palliative Care Consult Service/ARP Manager
- Ms. Darlene Befus - Physician Services Team Lead
- Ms. Sarah Dimitriou - Service Planning Consultant
- Supported by Ms. Christina Ollivier

Cumming School of Medicine Family Medicine Governance Council

- Dr. Charles Leduc - Academic Department Head
- Dr. Sonya Lee - Deputy Academic Department Head
- Ms. Allison Mirotchnik - Department Manager (LOA)
- Ms. Jane Bowman - Department Manager (interim)
- Mr. Craig Cutler - Business Analyst
- Dr. Keith Wycliffe-Jones - Postgraduate Program Director (vacated October 2018)
- Dr. Martina Kelly - Undergraduate Program Director
- Ms. Liza Worthington - Education Manager (vacated September 2018)
- Dr. Marianna Hofmeister - Education Manager (beginning October 2018)
- Dr. Turin Chowdhury - Scholarship Director
- Ms. Agnes Dallison - Research Manager
- Dr. Wes Jackson - Advanced Technology and Infrastructure Medical Lead
- Dr. Maeve O’Beirne - Director, Patient Medical Home and QI; Medical Director, Academic Clinics (beginning December 2018)
- Dr. Kamran Zamanpour - Medical Director, Academic Clinics (vacated December 2018)
- Mr. Scott Jalbert - Quality and Informatics Team Lead
- Dr. Michael Spady - Clinical Department Head, Family Medicine
- Dr. Ron Spice - Clinical Department Head, Rural Medicine & Academic Rural Director
- Ms. Meghan Prevost - Communications and Events Coordinator
- Vacant - South Zone Representative
- Supported by Ms. Michelle Gutkin



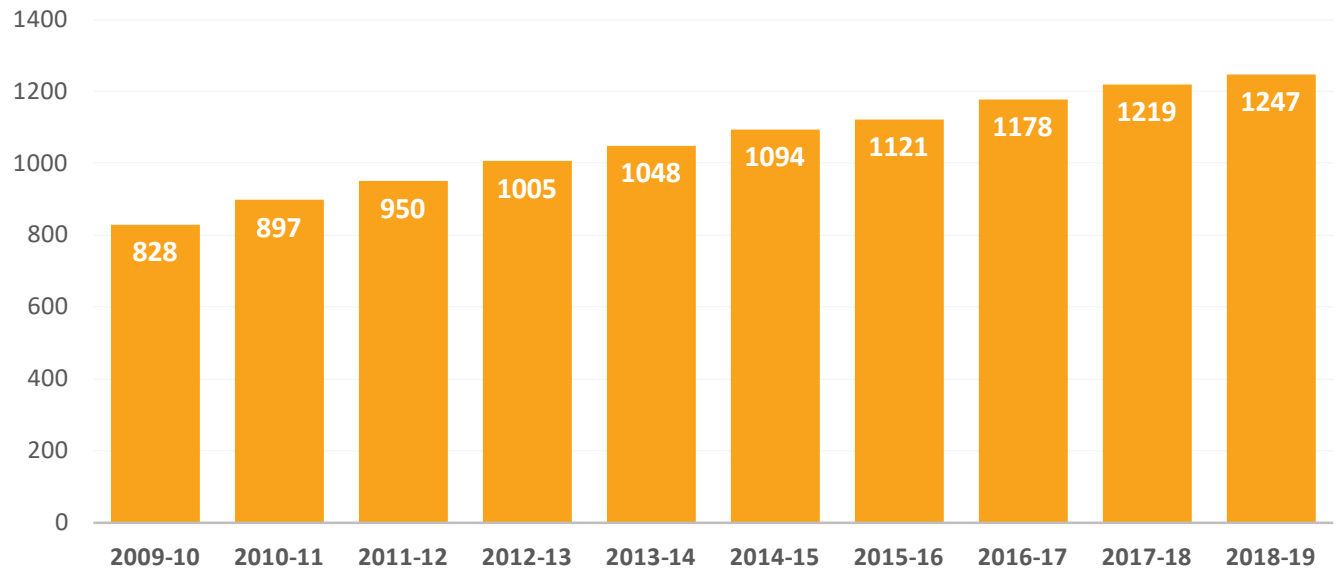


MEDICAL STAFF APPOINTMENTS

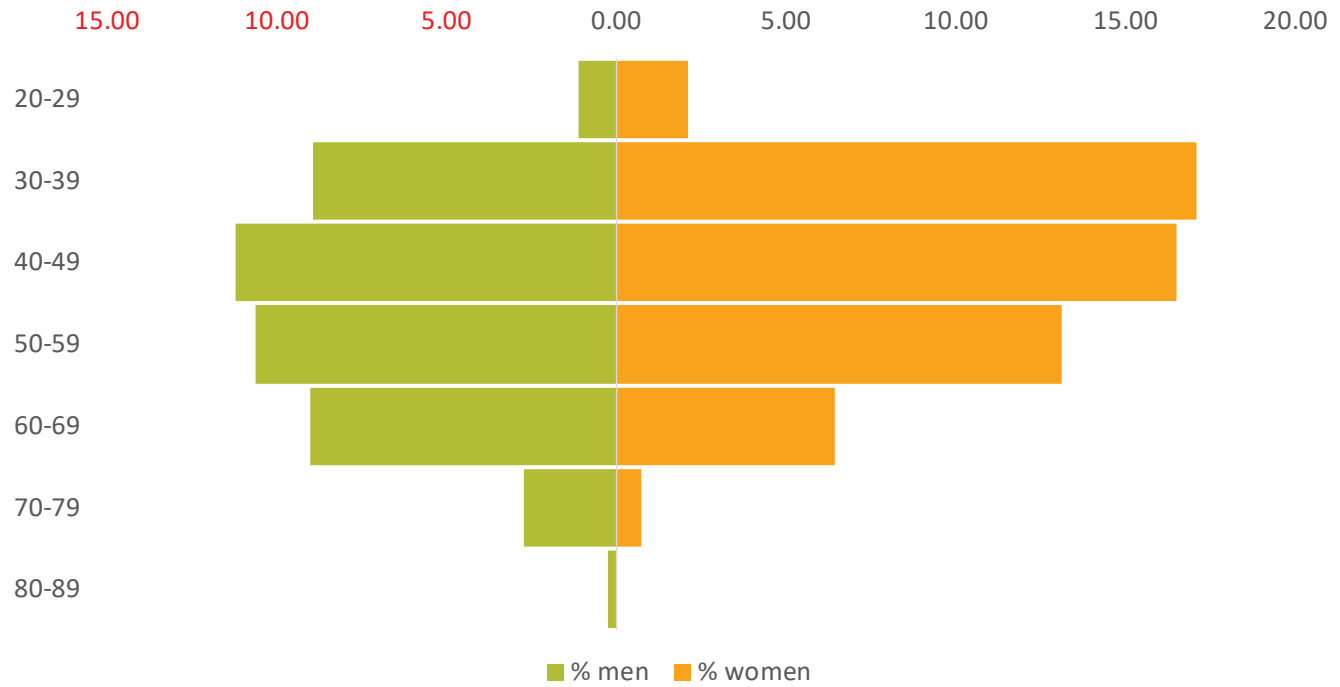
1247 physicians hold medical staff appointments with the Department of Family Medicine (DFM). Of these physicians, 1139 have a primary appointment with the DFM while the remaining 108 physicians hold a primary appointment in another department and a supplementary appointment with the DFM.

The following charts outline the growth in the DFM's physician membership since 2009 and the current age and gender distribution of physician members.

Medical Staff Appointments



Age and Gender - Medical Staff Appointments

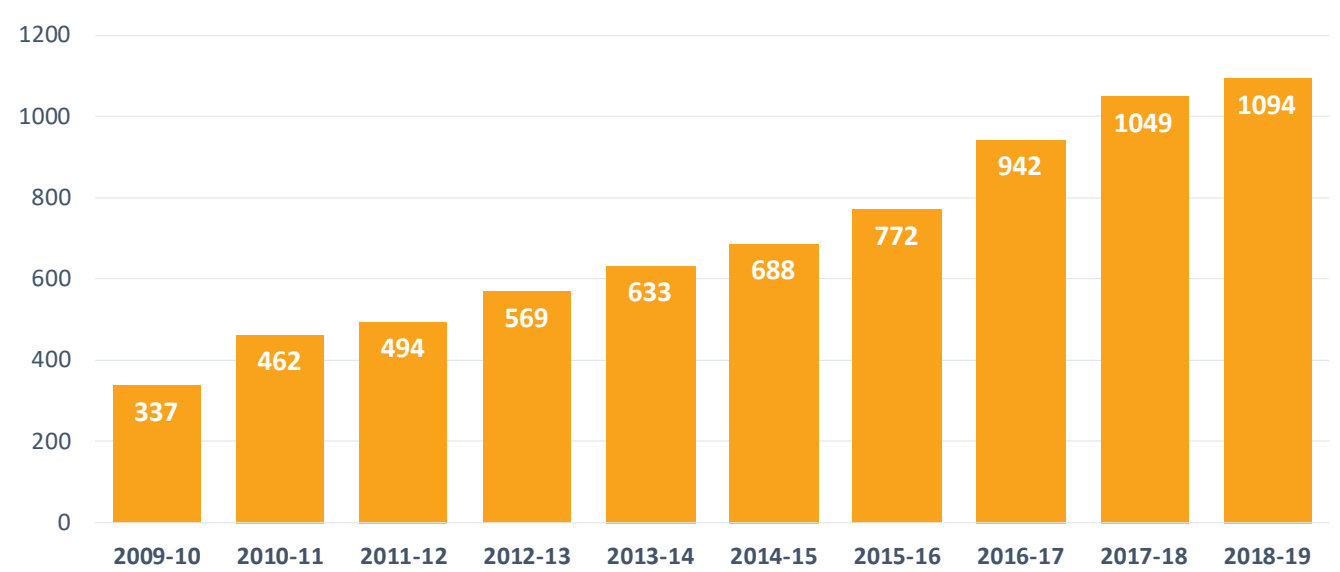


ACADEMIC APPOINTMENTS

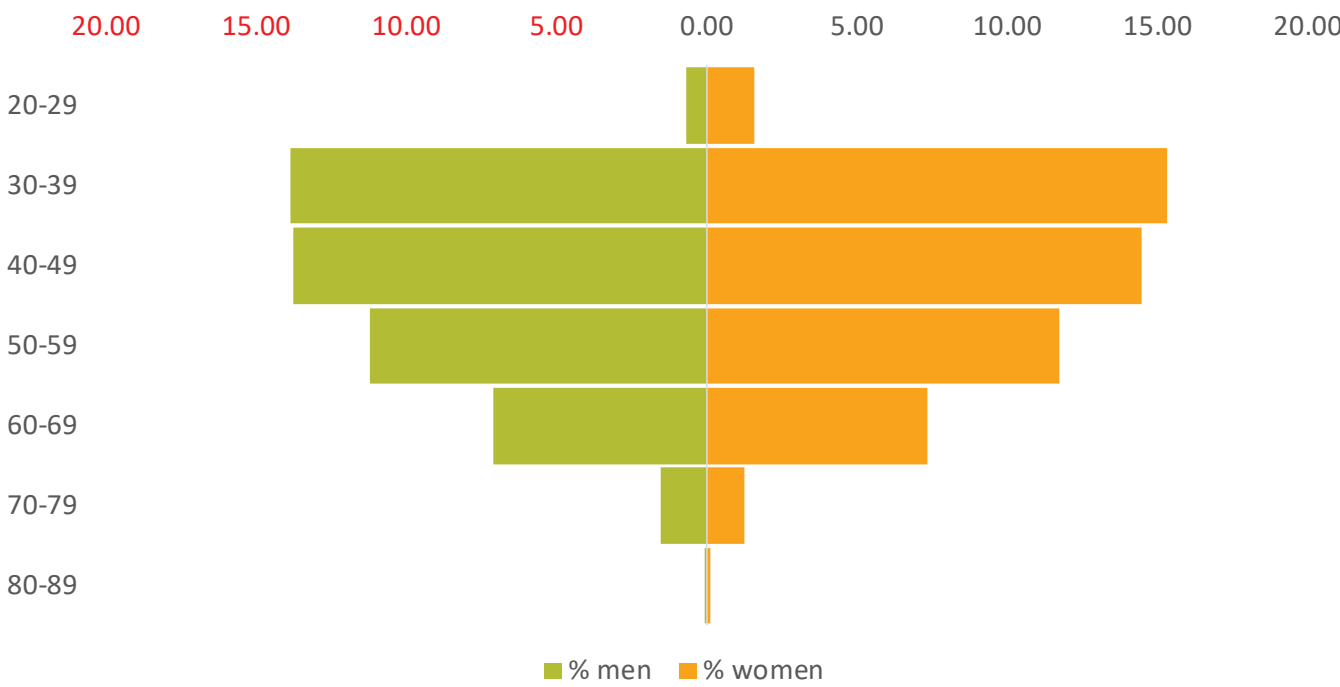
1094 physicians hold an academic appointment with the DFM. It is mandatory for physicians who are engaged in teaching family medicine residents at any level (undergraduate, clerkship, postgraduate, and/or enhanced skills) to have an academic appointment.

The following charts outline the substantial growth in DFM academic appointments since 2009 and the current age and gender distribution of physician members.

Physicians with Academic Appointments



Age and Gender - Academic Appointments



COMMUNICATIONS

Communications Strategy

The Communications committee is in the process of establishing a department-wide strategy that will inform and direct all communication activities to support the wider goals and objectives of the DFM.

The development of the strategic document will involve feedback and contributions from all areas of DFM operations to ensure that they are supported and engaged in the communication activities of the DFM.

DFM Newsletter

The DFM's distribution of the HomePage newsletter (delivered every second week electronically to physicians with medical staff appointments in family medicine) as well the Abstract newsletter (delivered monthly to all physicians with academic appointments) continue to be well received, with readership consistently hitting upwards of 45%.

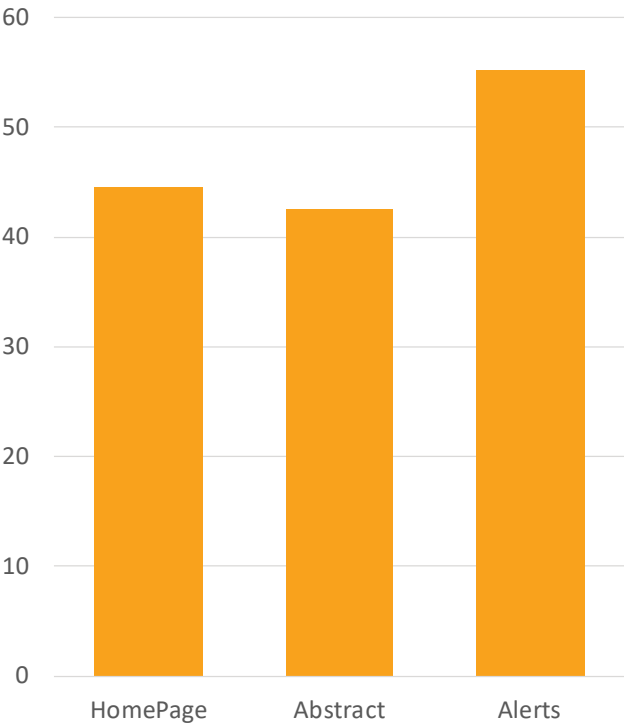
DFM Alerts

The DFM Alerts follow the red/yellow/green prioritization protocols established by the DFM and the Calgary Zone Primary Care Networks (PCNs) that categorize information by urgency – red being urgent and most critical, yellow being highly important, but not urgent, and green being non-critical information, shared via the HomePage newsletter.

From July 1, 2018 – present, five DFM Alerts (all yellow) were sent on the following topics:

- Notice of Change in Referral Criteria to Geriatric Medicine - Seniors Health Clinics with Calgary
- HIV Pre-Exposure Prophylaxis (PrEP) Prescribing
- Clarification of Referral Process for Calgary Zone Hip and Knee Arthroplasty programs
- Confirmed Case of Measles Prompts Public Alert to Potential Exposures (1)
- Confirmed Case of Measles Prompts Public Alert to Potential Exposures (2)

Average readership (%) for DFM Communications



Leadership Development

Truth and Reconciliation Through Right Relations

The DFM is cognizant of the importance of increasing awareness and understanding of Canada's shared history with indigenous peoples.

The DFM is motivated to raise the competency level for the DFM's physician and operational leaders relating to indigenous cultural diversity in Alberta and providing the opportunity to contribute toward reconciliation in Canada through an informed lens. To achieve these objectives, Banff Centre for Arts and Creativity hosted a one day

intensive, advanced training program. This learning experience allowed participants to partake in ceremony, in-person lectures, and outdoor walks to experience power of place, hands-on application of theory, individual reflection, and group activity.

This program transformed the ways in which leaders will make decisions, encouraged creative ideas, increased energy for current or new projects, and provided a deeper sensitivity to how the indigenous culture interfaces with the workplace and beyond.

Public Health Updates

New this year, the HomePage aimed to address a gap in communication between AHS Public Health and family physicians. The Calgary Zone Public Health portfolio identified a Medical Officer of Health who began providing content for the HomePage in the form of public health updates – articles on topics related to public health that would be of interest to family physicians. Public Health Updates on the topics of the diphtheria, tetanus, and pertussis combined vaccine (DTaP) for pregnant women and pneumococcal vaccine have been enthusiastically received and read by the HomePage readership.



Social Media

The DFM continues to gain traction on social media, with steadily increasing follower counts and interactions. On Twitter, @UCalgaryFamMed has increased its following to 759 followers. Impressions, profile visits, mentions and tags are also steadily increasing month over month, demonstrating good engagement and influence over Twitter. By connecting with stakeholders over Twitter, the DFM is able to foster informal relationships while promoting departmental success, and DFM events and projects to interested parties.

DFM now manages an Instagram account, @UCalgaryFamilyMed, and has steadily gained a following through the photo and video sharing platform, currently sitting at 178 followers.

DFM Website

The DFM website (www.calgaryfamilymedincine.ca) provides information and resources to DFM's various stakeholders. Website engagement is steady, with over 8500 users and 20,000 page views over the reporting period.

The most popular page on the DFM's website is the Physician Directory - accounting for 16.75% of page views, followed by pages for Continuing Professional Development, and Undergraduate Education - accounting for approximately 3% of page views each.



↑ 768



↑ 178

PHYSICIAN SERVICES

The physician services team enables physicians to fulfill their roles within Alberta Health Services (AHS), the University of Calgary, and the community.

The team achieves this by:

- Assisting physicians interested in practicing in Calgary to connect to current job opportunities
- Providing information about programs and clinical supports available to family physicians through AHS and partner organizations
- Helping physicians navigate the local licensing and practice readiness process
- Maintaining and engaging the workforce of the DFM's Academic Teaching Clinics
- Ensuring timely and accurate processing of medical staff and academic appointments
- Supporting the maintenance of appointments through Annual Information Verification Attestation (AIVA) documents collection and periodic reviews.

Medical Staff Appointments

The DFM is aligned with the AHS Chief Medical Officer's recruitment directive, which stipulates that all available positions comply with the clearly defined impact analysis process and be advertised through the Alberta Doctor Jobs website (www.doctorjobsalberta.com).

This direction has become increasingly important in the current environment of increased availability of physician workforce.

This year a total of 44 new medical staff appointments were processed along with 26 medical staff appointment terminations.

Academic Recruitment and Appointments

A total of 137 new academic appointments were processed this year in addition to 30 academic appointment terminations. There are 178 re-appointments identified for the upcoming review cycle.

Physician Engagement

In the current workforce environment, the team has adjusted its focus from recruitment of family physicians to Calgary, to the engagement, support, and retention of family physicians currently in practice.

To achieve this goal, the DFM holds events such as licensing and practice readiness, academic halfdays for Family Medicine residents, and the annual Family Medicine Showcase. This year's Showcase was combined with the Annual Mackid Lecture to maximize exposure to local family physicians.

To read more about the #DFMMainEvent, see the Community Primary Care section of this report.



COMMUNITY PRIMARY CARE

Dr. Monica Sargious - Section Chief

Annual Mackid Lecture

The annual Mackid Lecture is organized by the DFM thanks to a legacy fund from the Mackid family to support lectures and networking for physicians. This year, family physicians gathered on June 8th for the #DFMMainEvent. The event combined the 52nd Annual Mackid Lecture, a Physician Wellness Seminar, and the 18th annual Family Medicine Showcase. The event began with a lecture entitled “Adverse Childhood Events (ACE) - from Research to Practice” given by Nicole Sherren, Ph.D., and focused on The EmbrACE Project. Following the lecture, Dr. Ann Vaidya moderated a panel discussion with participation from Drs. Keith Dobson, Richard Lewanchuk, Sanjeev Bhatla, Van Nguyen, Teresa Killam, Nicole Sherren, and Penny Borghesan who shared practical knowledge of using Adverse Childhood Events Screening in practice.

MD Management and the Alberta Medical Association's Physician and Family Support Program facilitated a Physician Wellness Hour that focused on financial health for physicians and a presentation on compassion fatigue and burnout by Dr. Sharron Spicer.

Each year the DFM engages directly with patients to receive nominations for the Family Physician of the Year award.

Similarly, family physicians are asked to nominate a specialist colleague for recognition via the Specialist Physician of the year award. The Community Medical Staff Association (a subsidiary of Calgary and Area Medical Staff Society) hosted a wine and cheese social hour, where the Family Physician and Specialist Physician of the Year Awards were presented.

DFM AWARDS



Family Physician of the Year: Dr. Elizabeth Woolner

Dr. Elisabeth Woolner has been practicing family medicine for 29 years, providing care from pre conception to end of life, to multiple generations within her practice. She is a decorated family medicine teacher and an enthusiastic participant in PCN activity. Most recently, she has been an instrumental voice in the re-establishment of the Calgary Community Medical Staff Association.



Specialist Physician of the Year: Dr. Meriah Fahey

Dr. Meriah Fahey is an OBGYN physician in Calgary recognized by family physicians for her work with indigenous populations, immigrant families, and vulnerable patients with complex needs. Her nominators recognized her for being a champion advocate to Tsuut'ina patients, for her accessibility and communication skills, and for her enthusiasm and commitment to shared care and mutual respect toward her family physician colleagues.

The event wrapped up with the 18th Annual Family Medicine Showcase. The Showcase is an opportunity for Family Physicians and their team members to interact with each

other and various health care services representatives and learn about opportunities, supports, and services available for them and their patients in Calgary.

DFM Community Coalition

The DFM Community Coalition was created as a networking arena for primary care provider groups in Calgary to expand influence in health system transformation. Over the last year, the group discussed the Calgary Zone opioid crisis, indigenous health, seniors health, social determinants of health, marginalized patient populations, and enhancing care in the community.

This group leverages existing relationships in the health care system, and focuses on communication and connections, enabling a coordinated approach to meet the needs of the community.

DFM Physician Directory

The Physician Directory was initially funded by the Calgary Zone Primary Care Action Plan Committee and was developed by in-kind contributions from the DFM in 2013. In 2016, the Physician Directory web portal and database management system was redeveloped to centralize family physician data, which includes clinical contact information, PCN affiliation, address, phone and fax numbers. As of February 26, 2019, 1,795 physicians have contact information displayed on the Physician Directory that is pulled from DFM's Medicus Database. The DFM is working to ensure all practicing family physician clinical contact information is located on the Physician Directory, and developing a process to ensure all information is accurate and kept as up to date as possible.

AHS PRIMARY CARE COMMUNITY CLINICS

East Calgary Family Care Clinic

East Calgary Family Care Clinic is a people place! The physician and clinical model has created a high level of continuity for patients and the clinic is supporting all team members to work to their full scope of practice. One example of success in this area is that dietitians now have primary accountability for diabetes management within the clinic, which has in turn allowed the registered nurses to focus on intensive case management for their patients. The team has transitioned from disease-focused roles to a broader and more holistic case management system that includes a physiotherapist, pharmacist, and dietitians.

Recently, the clinic has further expanded its patient advisory group, now incorporating five patient advisers. Their opinions have offered a refreshing perspective on clinic issues. Using the input of patients, the clinic has refined their meet and greet process and how transitions between care providers are managed.

Academic Teaching Clinics

The Calgary Family Medicine Teaching Clinics are training sites for physicians and other disciplines in family medicine. Together with multidisciplinary team members, family medicine learners and physicians are committed to providing Calgarians with the highest quality of evidence-based medical care. Read more about the Academic Teaching Clinics in the Clinical/Medical Operations section of this report.

Elbow River Healing Lodge

The DFM is proud to have recently partnered more closely with Elbow River Healing Lodge (ERHL). ERHL is a unique and progressive family medicine clinic serving indigenous Albertans, blending western and traditional indigenous care pathways. The DFM looks forward to working with them and including more details in future reports.

CALGARY ZONE PCN COMMITTEE

A busy year of progress has created momentum and excitement in the Calgary Zone as the PCN Committee carries out the important work outlined in its first service plan, a blueprint for future work.

The service plan, endorsed by the Provincial PCN Committee, features project in four main areas: Mental health and opioids, the patient's medical home, specialty integration, and supported transitions. The committee is aligned in the vision of a healthcare system centred on the Patient Medical Home (PMH) model, enabling coordinated and continuous care for Albertans. As part of this work, local PCNs have started to develop a process to align business planning within the zone between all seven Calgary area PCNs.



Calgary Zone Primary Healthcare Opioid Response Initiative

Alberta has dedicated \$56 million towards urgent action to address the opioid crisis. The Alberta College of Family Physicians has a three-year, \$9.5 million provincial grant for a primary health care response, with sub-grants awarded to each of the five Zonal PCN groups to do frontline work in their communities. This grant aims to support increased access to services and provide training for primary care providers to offer treatment, medication, and care to patients and families affected by the opioid crisis.

The Calgary Zone response builds on past successes in access and integration efforts, such as Specialist LINK, by introducing safer opioid prescribing “frameworks” for use in medical homes.

1. Continuation of opioids when started in acute or specialty care

This involves collaboration with acute care partners to use common language and processes when prescribing and detailed and timely discharge communications to reduce risk when prescribing opioids.

2. Continuation of opioids for the management of chronic pain or in palliative care

To best support patients where they are at and to avoid leaving palliative patients without care at a very vulnerable time in their life. This framework also leverages Naloxone kit distribution as a harm reduction strategy for any patient with an opioid prescription.

3. De-prescribing of opioids

This includes treatment of Opioid Use Disorder with Opioid Agonist Therapy (OAT) while recognizing physicians' readiness for new skill development and creating linkages with existing OAT providers in AHS and the community.

The implementation of these frameworks is heavily supported by the Alberta Medical Association's change management packages, literature review, and guidelines from the Alberta College of Family Physicians peer group and individual PCN operations teams in their current medical home support structures. A truly sustainable new behaviour and culture around opioid prescribing should result, meaning the work continues long after the grant funding expires on April 1, 2020.

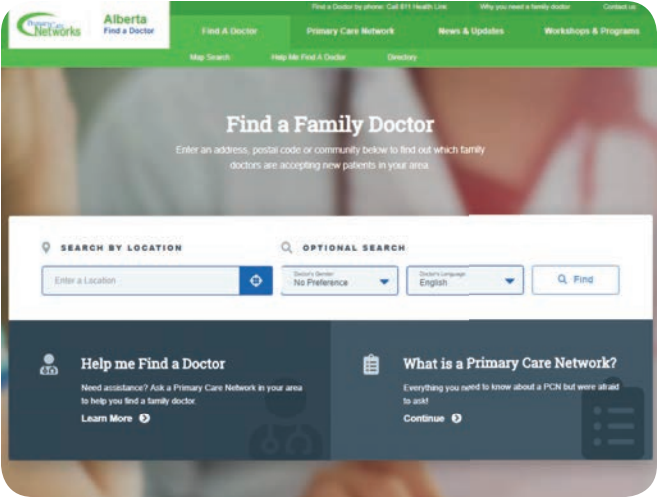
Supported Transitions

The Calgary Zone Find a Doctor website, first launched in 2010, has expanded into a provincial service (www.albertafindadoctor.ca), helping all Albertans to find a family doctor. This would not have been possible without a partnership with the Edmonton Zone and the PCN Program Management Office.

Over the past year, the Calgary Zone website has seen website traffic grow by almost 50% to more than 31,000 sessions per month.

The Supported Transitions group has also seen significant growth in the enhanced hospital transitions project that ensures all communication relevant to a patient's hospital stay is shared with the patient's family doctor. The project expanded to rural acute care sites and additional units within the City of Calgary this year. The process also helps identify patients who do not have a family doctor and enables patients to connect with a family doctor and their local PCN.

The Supported Transitions group will aim to develop a road map and implementation plan for people who need assistance to navigate transitions.



Mental Health

The Mental Health Task Group is working to identify which conditions could and should be managed in the medical home, key priority areas, and what support, resources, and education family physicians and PCN teams need to better support patients with mental health concerns in their medical home.

The task group organized and conducted an eating disorder continuing medical education event, started the production and development of an accredited non-suicidal self-injury educational video, and initiated work on a depression pathway.

The Calgary Zone submitted a proposal for grant funding to support mental health initiatives and develop and implement various projects over the next two years.

Deliverables include projects such as:

- creating educational videos for patients
- development of care pathways for providers
- creating a mental health resources platform
- organizing continuing education for physicians and multidisciplinary teams
- increasing shared mental health collaboration
- implementing rural initiatives
- developing materials to support continuous learning and education needs for physicians and
- multidisciplinary teams

Specailist Link

The rapid growth of Specialist LINK over the past year highlights the continued progress made by the Calgary Zone Health System Supports task group.

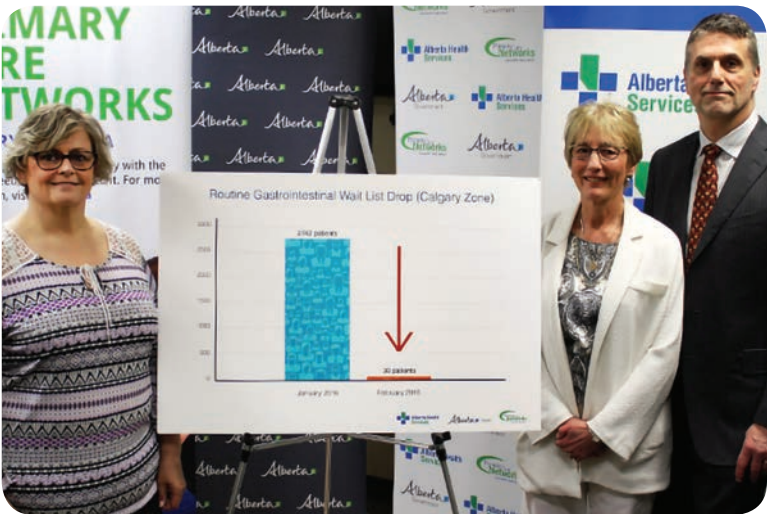
The task group aims to improve integration and communication between primary care and specialty care and has overseen the addition of four new groups, Palliative Care, Psychiatry, Urology, and Sports Medicine, to its tele-advice line bringing the total to 16 specialties. Nine new access or clinical pathways were also added, bringing the number available via www.specialistlink.ca to 22. The pathways, developed by specialists in partnership with family doctors, are designed to allow Calgary Zone physicians to care for their patients and access the support services that are available in the local area.

The real-time telephone advice line, which is available from Monday to Friday during office

hours, allows family physicians to request non-urgent advice online or through a toll-free number, followed by specialist will call back within an hour.

This service improves access and has resulted in shorter wait times for specialists, a reduction in unnecessary specialist visits, and health system cost-savings. Estimates show the healthcare system has saved more than \$1 million in its first four years of operation. Based on growth projections, those savings are expected to reach \$1 million per year by 2024. The task group also works closely with the team behind eReferral Advice Request to offer doctors an alternative to Specialist LINK by offering timely, non-urgent advice.

The Health System Supports task group will continue to add specialties to the tele-advice line, as well as develop clinical pathways for conditions commonly seen in primary care.



Patient Hayley Clarke, Dr. Linda Slocombe, and Dr. Mark Swain

1,159 patients were managed in primary care instead of a Calgary ED due to utilization of Specialist LINK

2,898 patients were managed in primary care instead of referred for specialist consultations due to Specialist LINK

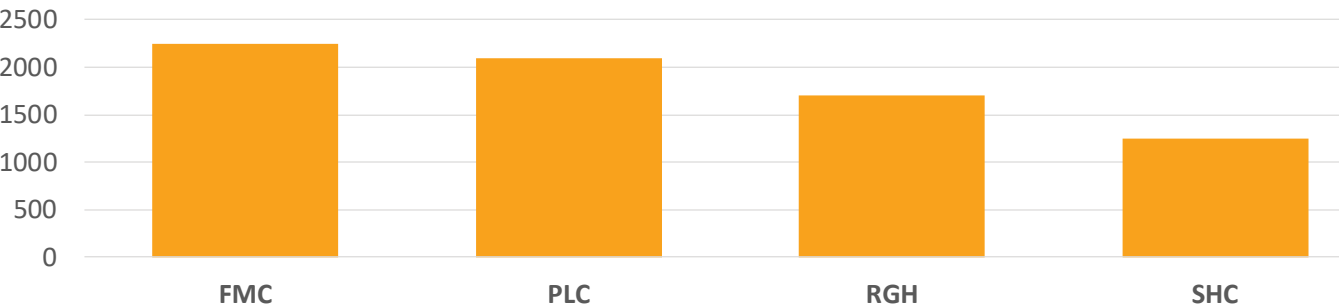
MATERNAL NEWBORN CARE

Dr. Norma Spence - Section Chief & FMC Site Lead
Dr. Allison Denesuk - RGH Site Lead
Dr. Valerie Lewis - PLC Site Lead
Dr. Deborah Hitchcock - SHC Site Lead

The Maternal Newborn Care section provides prenatal and obstetrical care in Calgary. Maternal Newborn Care physicians work in collaboration with a variety of care providers including obstetricians, midwives, pediatricians, anesthesiologists,

nurses, nurse practitioners, physician assistants, public health, community services, indigenous groups, PCNs, and other stakeholders to provide quality maternity, obstetrical, and newborn care at all four Calgary adult hospitals.

Number of Family Physician Admissions to Labour and Delivery in Calgary in 2018:



Fetal Heart Rate Surveillance

To prepare for Connect Care software roll-out, and the implementation of the intrapartum monitor technology that accompanies it, all hospitals in the province of Alberta will see a change from a 1 cm/min electronic fetal monitor tracing speed to a 3 cm/min tracing speed by December 1, 2019.

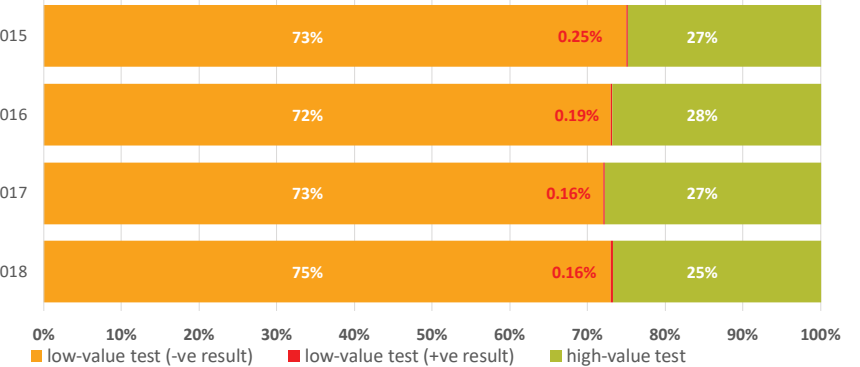
To prepare for the change in technology, all providers who interpret fetal heart rates must prove competence in the skill. Family medicine partnered with other specialties and sites to ensure maternal newborn care physicians have all the information needed to complete the required training.

Thyroid Stimulating Hormone testing in Alberta

The Maternal Newborn Care and Community Primary Care sections are collaborating with the Physician Learning Program (PLP) to review the value of prenatal Thyroid Stimulation Hormone (TSH) blood tests. Preliminary data shows that low value testing (testing women with no increased risk of thyroid problems) finds positive results 0.2% of the time.

Together with the PLP, the group will provide facilitated group learning sessions to implement best evidence and promote a reduction in low value TSH testing through informed practice change.

High-Value vs. Low-Value Tests



Breastfeeding Education

The need for a local guideline relating to tongue-tie assessment and treatment (frenotomy) was determined to be a priority for the Women's Health portfolio in the Calgary Zone. Through a multidisciplinary approach, family medicine initiated the development of the guideline, which was approved by the Zone Women's Operational Committee in September.

As a part of the guideline roll out, a workshop was held for family physicians, pediatricians, midwives, public health nurses, and other health care providers. The goal of the workshop was to review the changes to the guideline, the proper assessment of an infant's tongue function, and the resources available to patients in the community relating to breastfeeding.

Over 200 participants attended the session either in person at South Health Campus or via telehealth. Evaluations of the event showed a high interest in yearly events with similar content.



Iron Management

The section is looking to further advocate for patients and educate providers about target ferritin and hemoglobin levels in pregnancy, share information around appropriate investigations for postpartum patients, and inform practitioners about best practice treatment options.

Postpartum Hemorrhage

The family physicians delivering out of Foothills Medical Centre are excited to implement the postpartum hemorrhage (PPH) MoreOB initiative.

It focuses on improving the safety and satisfaction of maternity care by increasing early recognition and standardization of PPH management, increasing staff skill, confidence and team performance.

The strategy includes:

- a standardized risk assessment
- utilizing evidence based guidelines and a standard checklist
- a PPH emergency response cart to ensure that all supplies, equipment, and medication are immediately available
- routine incident debriefing that encourages all health care providers to provide feedback

MEDICAL INPATIENT CARE

- Dr. Jim Eisner - Section Chief*
- Dr. Peter Jamieson - FMC Site Chief*
- Dr. Alison Lewis - FMC Deputy Site Chief*
- Dr. Scott Wakefield - PLC Site Chief*
- Dr. Shereen Nessim - PLC Deputy Site Chief*
- Dr. Misty Watson - RGH Site Chief*
- Dr. Marinus van der Westhuizen - RGH Deputy Site Chief*
- Dr. Kobus Stassen - SHC Site Chief*
- Dr. Rattanjeet Vig - SHC Deputy Site Chief*

Medical Inpatient Care physicians (hospitalists) have a significant footprint in the four adult acute care centres in Calgary, admitting nearly two-thirds (60.9%) of medical inpatients, including the majority (> 96%) of family medicine admissions.

Nearly one in five admissions had longer lengths of stay or used more resources than expected for their presentation at

admission. Many hospitalist service patients have comorbid conditions which may complicate or prolong their admission. This is indicated by their comorbidity level, which is the number of other illnesses a patient has beyond the most responsible reason for hospitalization. The average comorbidity level for all hospitalist service patients was 1.11.

Hospitalist Discharge Summary Template

With the increasing complexity and need for smooth and informed transitions back to family physician medical homes in the community, discharge processes and transfer of information are vital. Discharge summaries are used to transfer information regarding a patient's acute hospitalization and communicate a care plan for follow up in the community. Current practice standards highlight the importance of a succinct, legible summary of active medical problems and management plan at discharge, including details on test results pending at discharge and specific follow up needs. A review of discharge summaries at Rockyview General Hospital revealed several areas for improvement including duplicate information best accessed elsewhere, lack of clear follow up, and incomplete medication reconciliation.

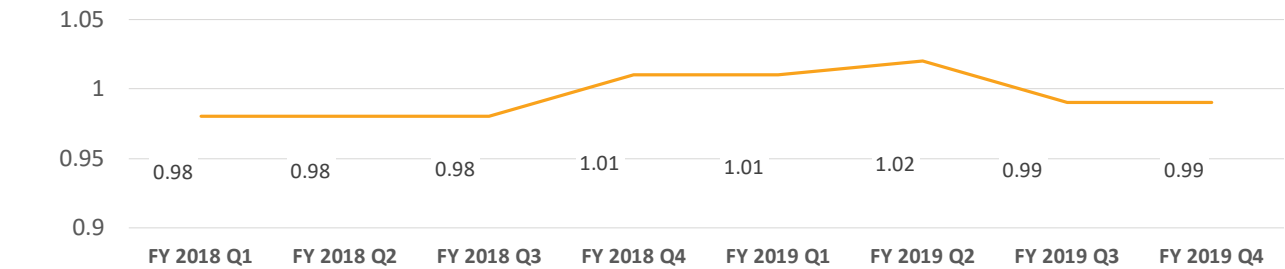
Based on these findings, a new template was developed with input from community representatives and hospitalist physician participation to improve information transfer. The template was launched at the Rockyview General Hospital in 2017. Following positive feedback, it was expanded to the other three adult acute care sites in Calgary. The hospitalist program strives to improve continuity of care for their patients. Next steps include optimizing the discharge template to align with existing workflows at each acute care sites, exploring opportunities for community feedback regarding the updated discharge summaries, and ensuring discharge summaries are finalized and made accessible to community physicians promptly after patient discharge.

ALOS/ELOS

Actual length of stay (ALOS) and estimated length of stay (ELOS) statistics help to measure efficiency of care in hospital, while readmission rates provide a quality measure that ensures a balance of efficient and safe care. Decision to admit times affect patient experience and quality of care (decreased time in the Emergency Department [ED] for admitted patients) and

represent a measure of efficiency within busy EDs as hospitalists endeavour to consult, assess, and admit appropriate patients as quickly and safely as possible. These measures are vital to ensuring the quality and performance of the Medical Inpatient Care section. The hospitalist service continued to maintain an overall ALOS/ELOS ratio in the range of 0.99 to 1.02.

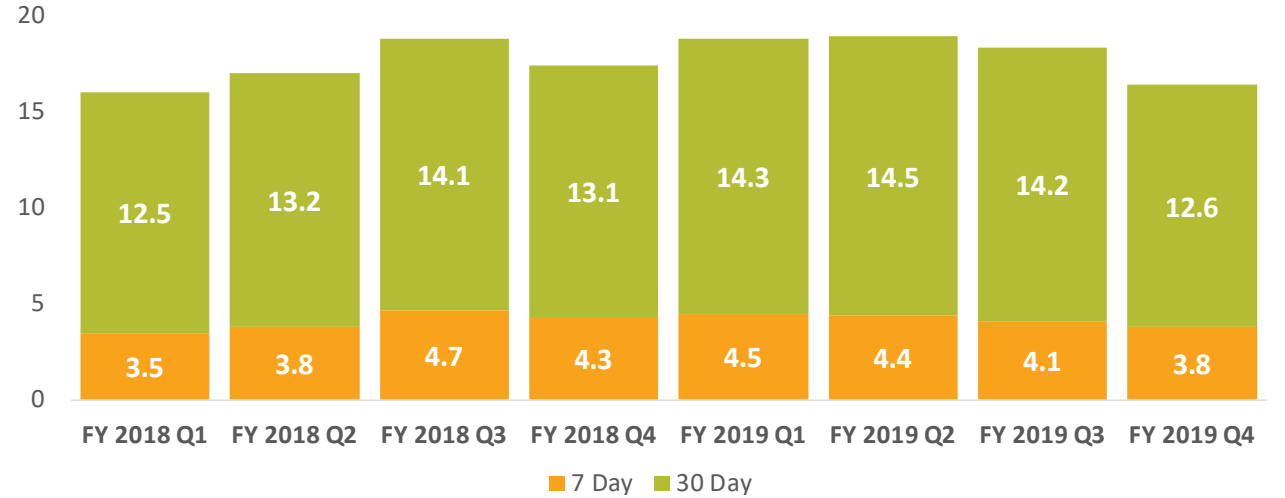
Hospitalist Patient ALOS/ELOS Ratio



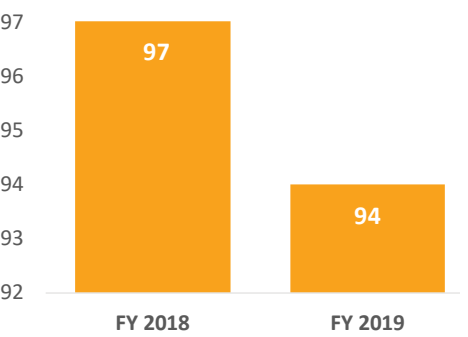
Readmission Rates

Readmission rates for typical hospitalist patients were consistent with previous years – just over four percent of patients were (3.8% - 4.5%) readmitted within seven days and slightly more than 14% (12.6% - 14.5%) were readmitted within thirty days.

Hospitalist Patient Readmission Rates



Decision to Admit Time



Decision to Admit

The target for decision to admit (DTA) is within 120 minutes or less, 80% of the time. The median DTA for the hospitalist service was 94 minutes, representing a decrease of three minutes over the previous year.

Medical Simulation

Recently the Code 66 program has initiated changes that require the attending service physicians to coordinate more directly with the multidisciplinary team in the presence of an acutely deteriorating patient.

To address this, the hospitalist service organized ACLS certification courses for their physicians. In addition, the hospitalist service will develop a simulation program specific to the needs of the hospital team and physicians.

Physician Wellness

With focus on physician wellness increasing across the country, two hospitalists at Rockyview General Hospital are in the planning stages to undertake a project to address wellness amongst the hospitalist physicians.

A survey of the current state is planned for early in the next fiscal year, which will assess the level of hospitalist physician burnout and overall wellness. Survey results will inform potential strategies to improve hospitalist physician wellness.

The physician leads are working to engage stakeholders within AHS to coordinate their efforts in the development of an integrated physician wellness program.

Quality Assurance & Quality Improvement

The hospitalist group is very involved in developing and leading a variety of site level quality improvement (QI) initiatives specific to issues identified by the hospitalists and/or supporting zone-wide QI initiatives.

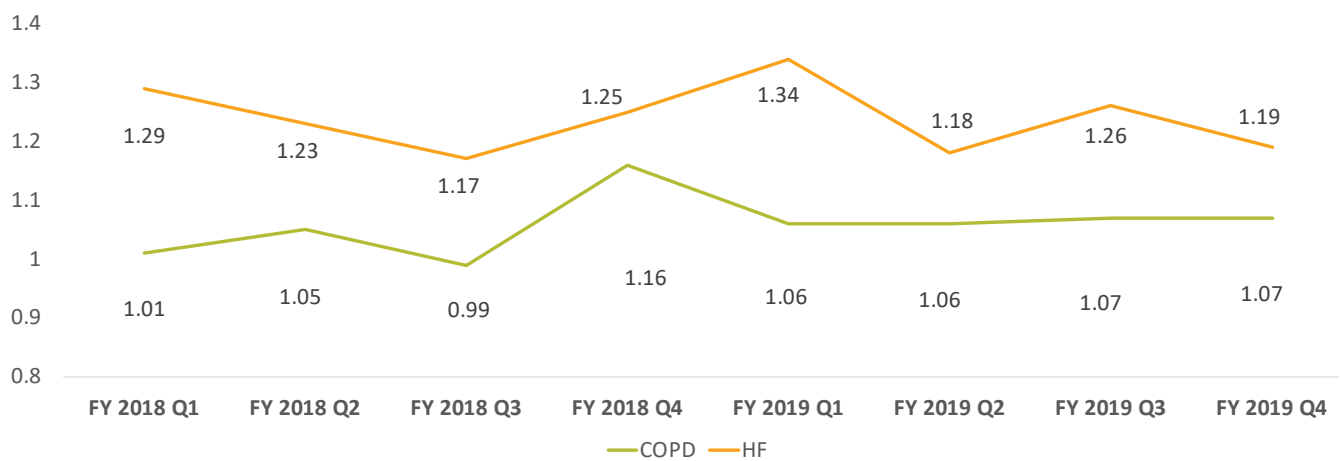
The Hospitalist Opioid Action Plan (HOAP) began in 2017-18 with naloxone kit teaching and distribution, and has expanded to a focus on continuing medical education related to opioid use and opioid replacement therapy for admitted patients.

A small group of physicians at two sites have been trained in and will begin participating in a unit-level pilot of the Serious Illness Conversation Project initiated by palliative care.

The section has created a physician dashboard which provides individual metrics has supported improvements in ALOS/ELOS, readmission rates and decision to admit times. The dashboard allows physicians to review their performance relative to their peers via an audited feedback mechanism as part of their periodic review.

Patient complexity continues to be a challenge to the service and staff. Maintaining safe goals for ALOS/ELOS and corresponding readmission rate monitoring is increasingly difficult.

Hospitalist COPD/HF Patient ALOS/ELOS Ratio

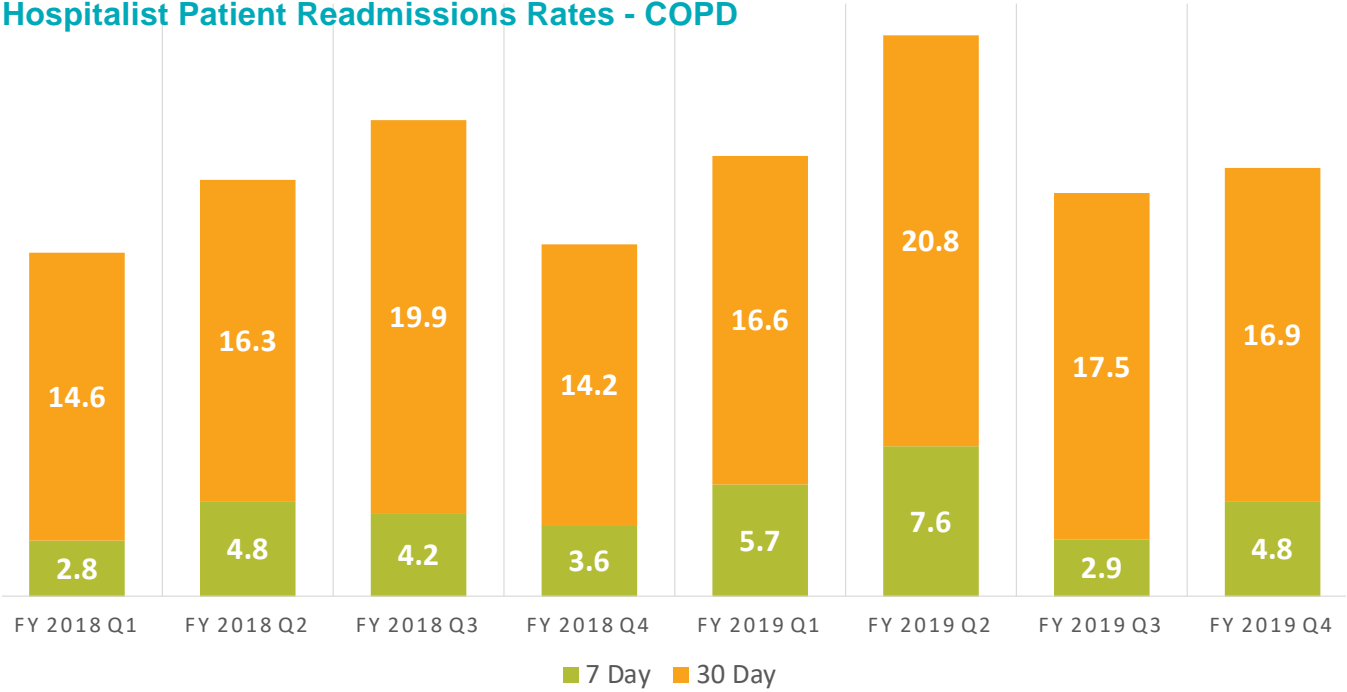


Patients with Chronic Obstructive Pulmonary Disease (COPD) or heart failure (HF) comprise approximately 13% of all hospitalist service discharges and approximately one of every 10 patients (9-12%) within these two cohorts was classified as atypical (i.e. with comorbid or social factors outside of typical presentations).

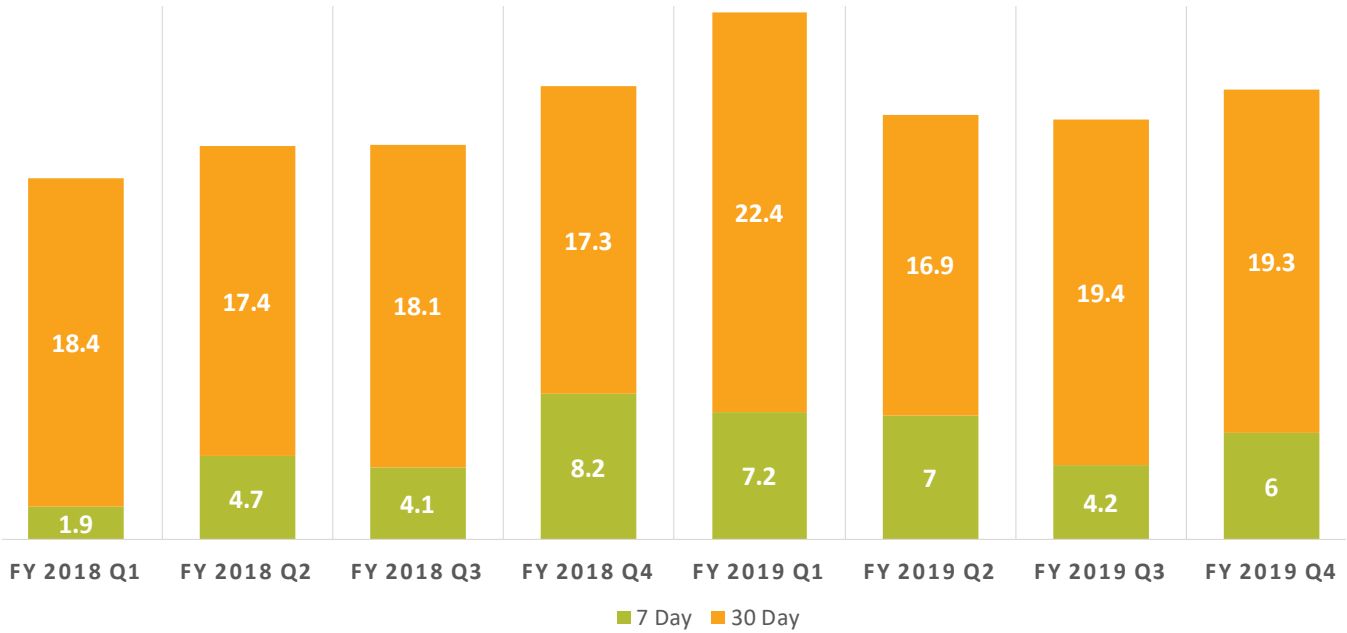
The average comorbidity level was higher for COPD patients than for the hospitalist service as a whole (1.15 v. 1.11) and they tended to stay in hospital longer and were readmitted at higher rates than the average for hospitalist service.

HF and COPD continue to be a focus for the medical inpatient section and AHS. The section is working with Strategic Clinical Networks (SCNs) and PCNs as a part of a larger strategy to improve care for these patient groups.

Hospitalist Patient Readmissions Rates - COPD



Hospitalist Patient Readmissions Rates - HF



URGENT CARE

Dr. Matt Hall – Section Chief and Medical Director (until December 31, 2018)
Dr. Charles Wong – Section Chief and Medical Director (as of March 11, 2019)
Dr. Evan Bensler – Sheldon M. Chumir Health Centre Urgent Care Site Lead
Dr. Lanette Prediger – South Calgary Health Centre Urgent Care Site Lead

The two Calgary Zone Urgent Care Centres (UCCs) work closely with their rural partners in Airdrie, Okotoks, and Cochrane to provide extended-hours care to their respective communities. The section holds the distinction of being the largest group of Urgent Cares operated by a regional health authority or hospital system in Canada. The mandate of the UCCs remains to be to serve patients requiring immediate care for non-life-threatening medical conditions.

Both the Sheldon M. Chumir and South Calgary UCCs have continued to provide remarkable service to their communities. The Sheldon M. Chumir UCC has provided consistent and responsive medical service, evidenced by stable wait-times and length-of-stays despite an increasingly complex patient

demographic. South Calgary UCC's volumes have remained stable since the establishment of the South Health Campus in 2013. Workflow adjustments have allowed decreases in 'time to physician assessment' in spite of increasing acuity.

The UCCs have responded remarkably well to the growing population in Calgary, meeting the needs of tens of thousands of Calgarians each year. As the complexity and acuity continues to increase, the Executive Team will be developing a mission statement and the strategic direction for the section in the coming year. The purpose of this project is to define the scope and breadth of the UCCs, especially in terms of how they can complement and support the work of family physicians, and acute care centres including emergency departments.

Opioid Crisis Response

The urban UCCs continue to see a rise in both the volume and severity of opioid related presentations. The section is responding to the opioid epidemic by initiating a leading edge opioid-replacement therapy (Buprenorphine- Naloxone, or Suboxone) program that is closely linked to community partners for follow-up.

The Sheldon M. Chumir UCC, being a focal point of the opioid response in Calgary by the close proximity of a regional supervised consumption site, has led the march on suboxone prescriptions.

Point-of-care Ultrasound

A SonoSite point-of-care ultrasound machine for the South Calgary UCC was procured, and formal training has been provided to the physicians.

The Sheldon M. Chumir UCC continues to utilize their device extensively for both patient care and education. Ultrasound remains an area of physician interest, and the Urgent Care section is pursuing the development of a coordinated training strategy to optimize competency with the device at all the sites, drawing on the considerable expertise within the physician group.

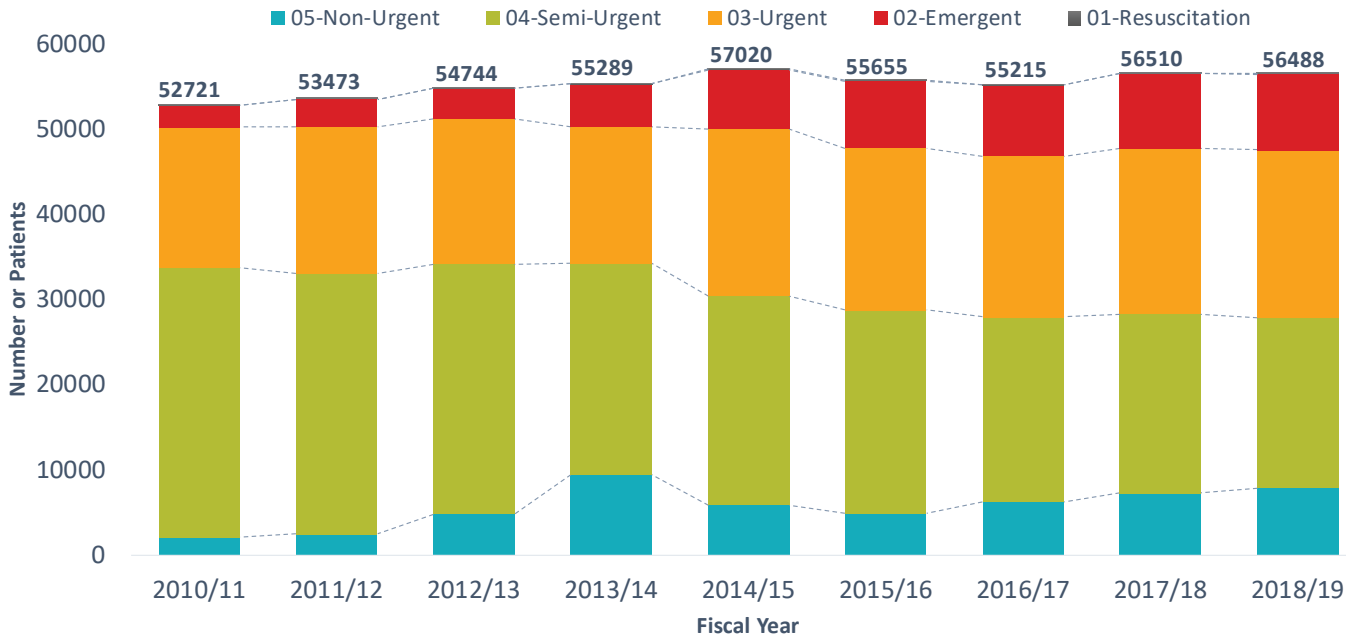
New Medications

With improved patient experience and safety in mind, the UCCs have started using propofol as one of many options for procedural sedation. Propofol provides a lack of awareness and analgesia for painful procedures such as fracture reductions or abscess drainages. Its faster metabolism allows for quick patient recovery thus decreased patient treatment and monitoring times. Educating physicians on how to incorporate propofol into their practice involved a didactic seminar provided by a local emergency physician, as well as two online learning modules.

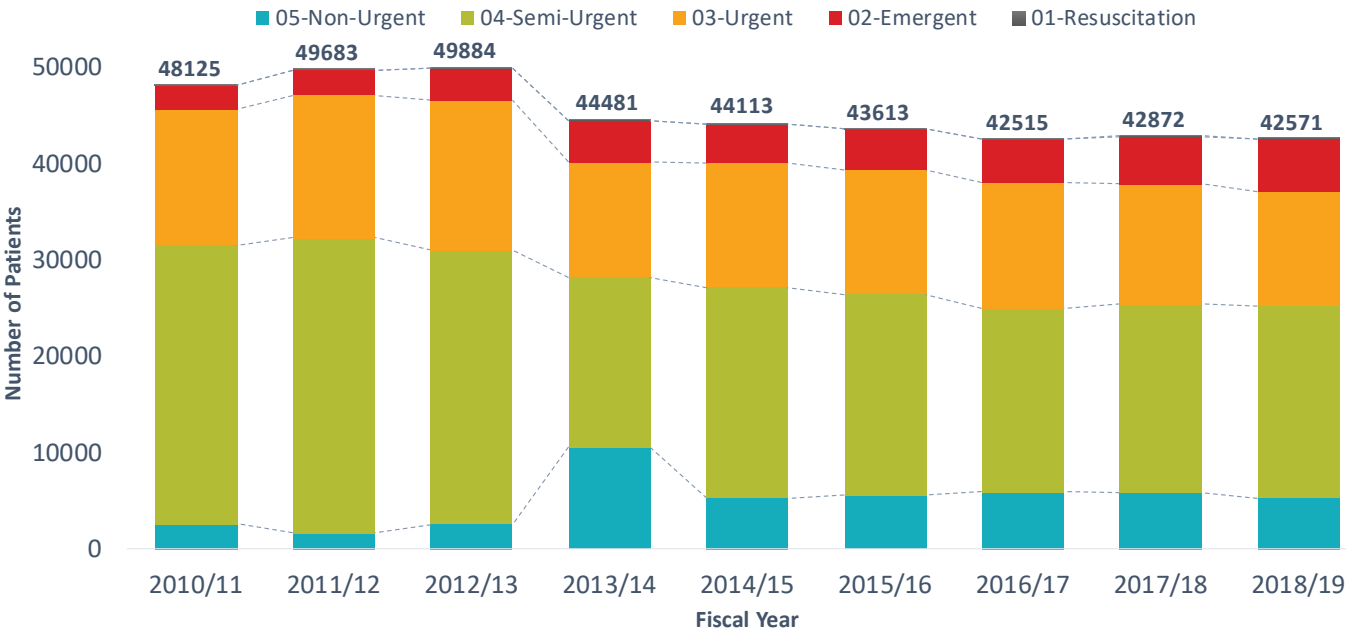
High Sensitivity Troponins

In a coordinated effort involving the Departments of Biochemistry, Family Medicine, Emergency Medicine, and Alberta Public Laboratories, all UCC sites will be transitioning to a high-sensitivity troponin (hs-TnI) in May 2019. The higher sensitivity test should lead to faster and more accurate diagnoses of acute coronary syndromes, as well as more efficient transfer-of-care to acute care facilities. Local troponin research experts developed an evidence-based chest pain protocol that has been disseminated through educational rounds at each site.

Total Presentations by CTAS ScoreSheldon M. Chumir Health Centre Urgent Care

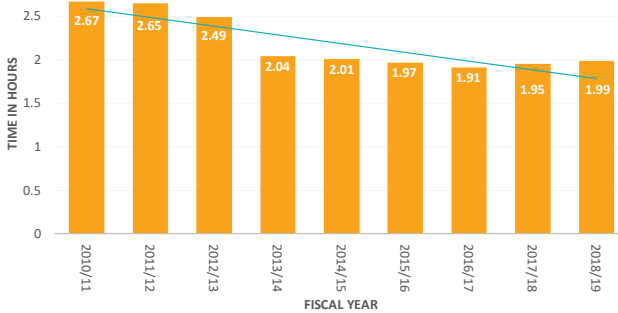


Total Presentations by CTAS ScoreSouth Calgary Health Centre Urgent Care

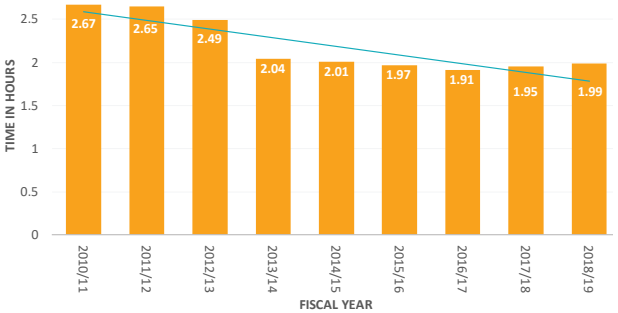


Average Time to Physician-Initial-Assessment

South Calgary Health Centre

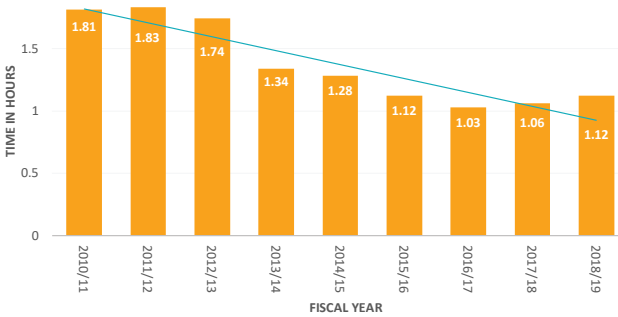


Sheldon M. Chumir Health Centre

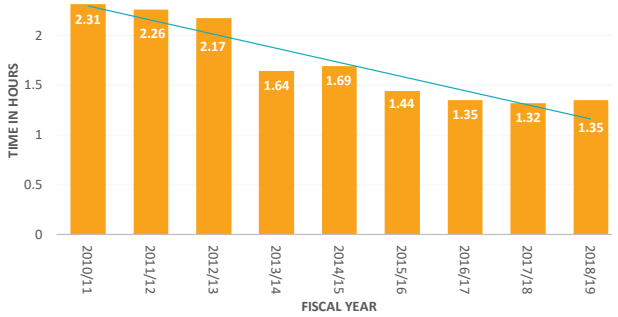


Average Length of Stay

South Calgary Health Centre



Sheldon M. Chumir Health Centre



Research and Quality Improvement

The UCCs are delighted to be a part of a vibrant academic community and support medical research in numerous facets. The urban and rural UCCs are part of a multisite randomized control trial evaluating the effectiveness of ketotifen for post-traumatic elbow contractures, and are involved in a study of the diagnosis of occult scaphoid fractures. The section

is cooperating with Clinical Biochemistry to evaluate the correlation of the new hs-TnI to the acute care hs-TnT. The Sheldon M. Chumir UCC is investigating the needs of high-frequency utilizers and are working with the Department of Emergency Medicine on complex care plans for patients that may benefit from a collaborative, cross-facility approach.

PALLIATIVE CARE

Dr. Aynharan Sinnarajah - Section Chief
Dr. Russell Loftus - Deputy Section Chief

There are 35 palliative physician consultants in the Calgary Palliative Care section, and they provide support to palliative patients across all service areas in the Calgary Zone. Additionally, 44 hospice physicians work within seven Calgary hospices as the Most Responsible Provider. All Palliative Care clinical work is delivered through the AHS Calgary Zone Palliative End of Life Care (PEOLC) program. Palliative physician consultants are also active members within the Department of Oncology, Division of Palliative Medicine.

Education, Quality, and Safety

The 18th Annual Mary O'Connor Palliative and Hospice Care Conference was hosted in May. The theme was Palliative Care: Passages, Gifts, and Messages and attracted over 600 participants from across the province.

Calgary Zone Medical Assistance in Dying (MAiD) and Palliative Care teams worked together to develop Principles and Guidelines for Collaborative MAiD & Palliative Patient Care, Team Processes & Supportive Reviews to codify best practice for how both groups can collaboratively work together when both teams are involved in care.

The PEOLC Patient Family Centred Committee, with input from patient and family advisors, developed a brochure for patients outlining the services available to them and their families. These brochures are available online and have been very well received to date (www.ahs.ca/info/Page14778.aspx). Using photos, videos, music, and their own voice, five family advisors tell their story of what mattered most to their loved ones during their experiences of palliative and end of life care. These digital stories are posted on the AHS YouTube channel under 'Palliative Digital Stories'.

The Palliative Care Early and Systematic Project

The Palliative Care Early and Systematic (PaCES) project team is a province-wide team of clinicians, physicians, health system users, and researchers working together to develop and deliver an evidencebased early and systematic palliative care pathway for advanced colorectal cancer patients and their families in Alberta.

The new clinical practice guideline and pathway provide a new standard of care for screening, identifying, and managing unmet needs of patients and their families/ caregivers who may benefit from an early palliative approach to care. Many resources and educational materials have been developed to support the new pathway, and are housed online at www.ahs.ca/guru. Healthcare providers will find tips such as:

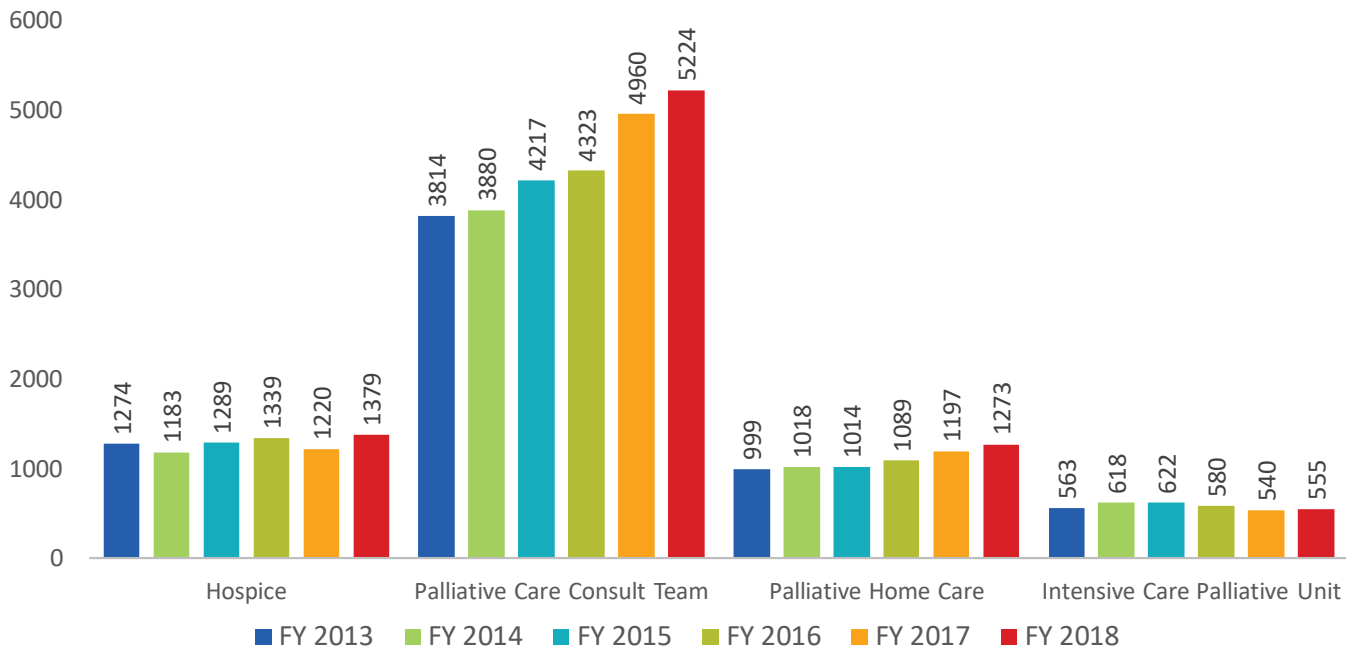
- how to access Home Care for patients
- referral based service descriptions
- symptom summaries
- scripts for introducing palliative care
- examples of shared care letters for family physician/cancer centre information exchange

DEPARTMENT OF FAMILY MEDICINE



PROGRAMS

Utilization by Program Area



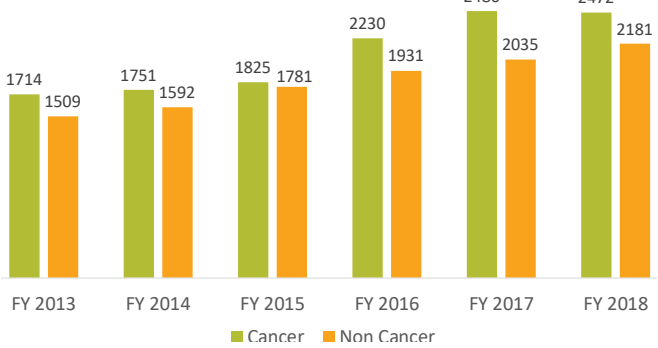
Hospices

Hospice teams have been engaged to develop care plans that are reflective of patient end-of-life needs and individual goals. These care plans are personalized to reflect individual hopes such as the ability to spend quality time with family, attend a wedding or graduation, or host a family reunion at the hospice. The teams have also begun the process of reviewing educational requirements for all members of the interdisciplinary healthcare team serving hospice families. Of the 1397 patients who were admitted to hospice, 32% had a diagnosis other than cancer.

Palliative Care Consult Service

All acute care sites have implemented a central palliative pager that enhances direct conversation with a palliative consultant, and have improved access to palliative consultation. These access points also now include the availability of referral forms for all community locations on the Alberta Referral Directory, Netcare e-Advice, partnering with Specialist LINK, Referral, Access, Advice, Placement, Information, and Destination (RAAPID), and the EMS Assess Treat Refer program via 911. A summary info sheet on how to access Calgary Palliative Care is available on the Specialist LINK website.

Palliative Consult Admissions by Diagnosis





Intensive Palliative Care Unit

The Intensive Palliative Care Unit (IPCU) provides tertiary level, short stay palliative care for patients with complex palliative or symptom needs until patients are ready to be transferred to the most appropriate setting for ongoing palliative care such as home or hospice. The IPCU team continues to be actively involved in the planning of the palliative care unit within the much-anticipated new Calgary Cancer Centre. Tracking of patient-reported outcome data (e.g. the Edmonton Symptom Assessment System) through Tableau began this year. Patients admitted to the IPCU have access to a well-resourced multidisciplinary team that includes physiotherapy, occupational therapy, social work, registered dietitian, recreational therapist, and spiritual care provider.

Grief Support Program

To bridge the wait time between registration and attendance at the first session, the program offers a monthly education night to provide support and normalize the experience of grief for clients.

To continue to increase healthcare provider capacity to support the bereaved, How to Care, What to Say, and Grief and Adjustment through a Trauma-Informed Lens workshops continue to be offered to palliative care staff and providers.

The Calgary Zone Rural Palliative Care In-Home Funding Program

The Calgary Zone Rural Palliative Care In-Home Funding program was developed as a way to support rural clients with palliative conditions to stay at home when they require care beyond existing community services. The program allows families to recruit, contract, and direct care providers, and families are supported in navigating the streamlined contracting and payment processes.

Care providers can include individuals who do not have formal healthcare training. This connection is a particularly important program element in more remote areas, but also an exciting patient-centered initiative that engages communities.

Since the program began in October 2017, the program has provided 450 total days of support and over 9,000 hours of care to 104 rural clients and families, 82% of whom had a diagnosis of cancer. 92% of clients were able to die at home or in a hospice facility, with only 8% requiring an acute care admission at the end of life. With the flexibility in provider criteria, 15% of the care hours were delivered by providers with no formal health care designation.

AHS is looking to expand the program to the rest of Alberta and has been adopted by the Canadian Home Care Association as a High Impact Palliative Home Care Practice.

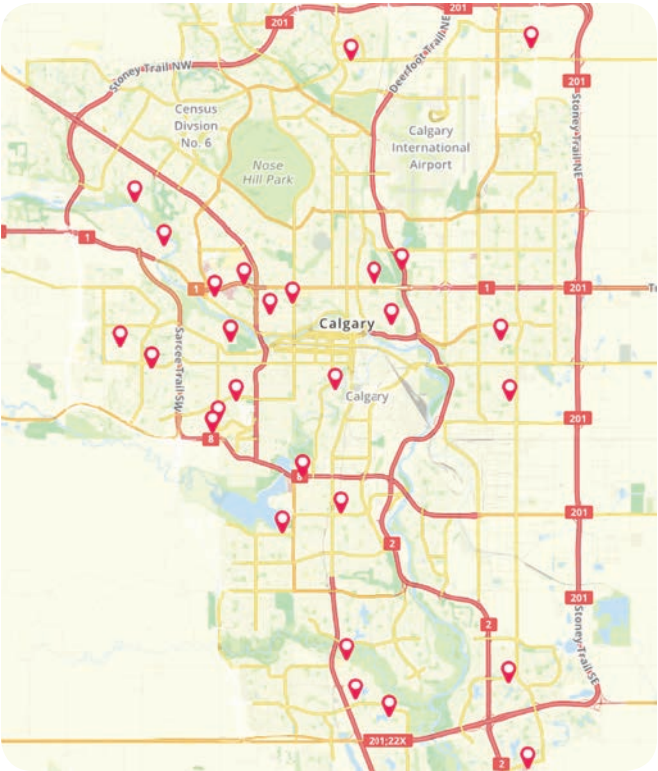
SENIORS CARE

Dr. Vivian Ewa – Section Chief

There are 8,594 continuing care beds in Calgary, an increase of 732 over the year.

Facilities have opened various specialty programs, such as mental health and addictions, to serve better the local population, which has reduced the number of patients who are awaiting placement while in acute or subacute care facilities.

In the upcoming fiscal year, an additional 577 new long term care (LTC) and supported living beds are projected to open, along with 311 non-designated beds.



QUALITY IMPROVEMENT

Primary Care

The increasing demand for their program, coupled with the growing waitlist, prompted the Specialized Geriatrics Outpatient Clinic to review their referral criteria for the program. Through the review referral changes in criteria occurred and family physicians whose patients did not meet the requirements were directed to resources for their patients, such as the Home Care Geriatric Consult Team and the Seniors Health Outreach Program to Facility Living. Looking ahead, the clinics will work with primary care to build capacity to help diagnose and manage dementia within primary care clinics.

Home Based Primary Care for Frail Homebound Adults

Developed by the Calgary West Central PCN and AHS Home Care, the Seniors Home Based Primary Care Demonstration Project brings the medical home to frail homebound older adults. This population often has complex and inter-related health and social needs, putting them among the most vulnerable and marginalized patient populations.

Patients who are part of the program are receiving access to primary care services such as appropriate screening, advanced care planning, and referrals to community and specialist services reducing emergency department visits and hospital admissions, enhancing patient safety and quality of life.

Pain Management

The Pain Assessment in Advanced Dementia Scale (PAIN-AD) is based on healthcare provider observations, and therefore can be used in persons unable to communicate pain symptoms.

The Carewest Colonel Belcher conducted a QI project using the PAIN-AD tool with their dementia patients. They found:

- An improvement in pain monitoring leading to opioid reduction
- 81% of the staff felt the tool improved recognition of pain
- 77% of staff felt the tool enabled them to discuss pain symptoms and response to treatment with other members of the team including physicians
- Improvement in Resident Assessment Instrument Minimum Data Set (RAI-MDS) scores such as aggression and depression

Health Quality Council of Alberta
Patient Experience Award

The Brenda Stratford Foundation was a recipient of the Health Quality Council of Alberta (HQCA) Patient Experience award for the development and implementation of a patient and family-centered End of Life Framework and Program in 2018. Using a new tool, the Palliative Care Bullseye Framework, in conjunction with validated tools such as the Palliative Performance Scale and the Personal Severity Index and a multidisciplinary approach, the End of Life Framework and Program improves patients experience in the facility.



SPECIALIZED PSYCHIATRIC
PROGRAMS

An increase in Calgarians who struggle with mental health and addictions have led to the opening of additional community-based specialty programs. These programs include the LTC Mental Health unit at AgeCare Skypointe, Young Adult unit at Bethany Calgary, and the Complex Dementia Care unit at Bethany Riverview.

LTC Mental Health Unit

The Agecare Skypointe Mental Health Long Term Care program has two units with 32 beds. One of the units is a secure environment.

The resident population includes those who require 24 hour supervision and a primary mental health diagnosis (for example, bipolar disorder or schizophrenia) as well as some degree of medical complexity. Many of them are quite young compared to the Long Term Care standard. Often these residents have been difficult to place in traditional LTC programs.

The site provides resources targeted at the mental health population and a staff complement including a liaison psychiatrist and attending physicians who are hospitalists that can facilitate direct admission and continuity of care in hospital.

The unit has been successful in providing an environment where residents with sometimes challenging mental and physical health care issues can get the care they need without requiring hospitalization.

Young Adult Unit

This unit has a total of 26 residents who are between 31 to 59 years old with four physicians providing care. Their approach to young adult care is centered on services that foster self-determination, choice and reflects Bethany's philosophy of

care built on the principles of person centered, relationship focused, therapeutic, and enabling environments.

The young adult team works collaboratively with residents to support and maintain functionality and independence as long as possible. Providing residents the comforts of home while at the same time supporting socialization in our communal areas is their goal.

Complex Dementia Care

This program is now located in the Bethany Riverview where 120 beds are dedicated to people with complex dementia. Care is provided by family physicians and psychiatrists.

The team uses specialized approaches and best practices for effective behavioral management of individuals with complex behaviors associated with dementia. Using a resident-centered approach, they help individuals and families work through the challenges presented by this complex disease, with the goal of stabilizing behaviors so the individual can move to a more traditional care environment.

The commitment to creating a homelike environment with a focus on expert dementia care we will improve the quality of life for residents and their families in all stages of their journey with dementia.



EMERGENCY DEPARTMENT
COLLABORATION

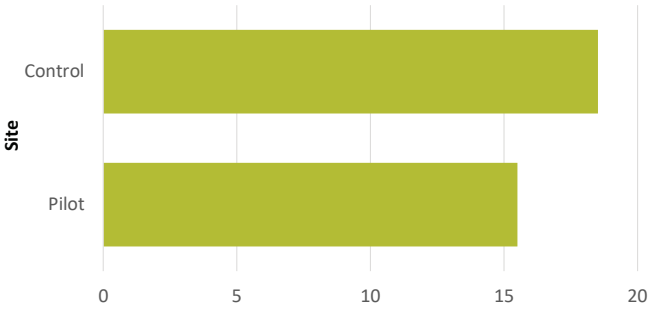
Long Term Care / RAAPID / Emergency
Department Pilot Project

The LTC/RAAPID/ Emergency Department (ED) Pilot Project was a recipient of the Quality Innovation Fund grant through AHS's Chief Medical Office. The goal of the project is to improve transitions of care and communication between long-term care facilities and Calgary EDs by using RAAPID.

Since March, the average LOS in ED for these patients has dropped from 18.5 hours to just over 15 hours.

Emergency Department Avoidance

The Walden supportive living facility conducted a QI intervention that included the implementation of the Early Warning Stop and Watch tool, which enables staff to observe and identify potential changes in a resident's condition. The success of this QI intervention is being extended to other supportive living sites.



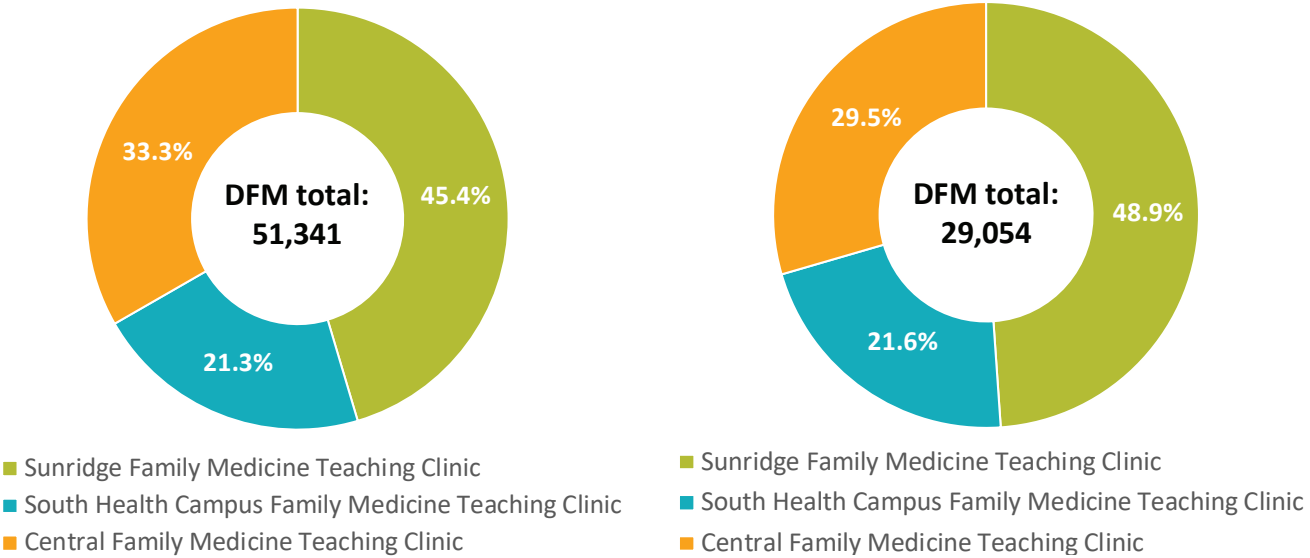
Transfers to Calgary EDs
decreased by 27% since 2017
(3.3 – 2.4 transfers per
1000 resident days)



CLINICAL/MEDICAL OPERATIONS

Dr. Kamran Zamanpour – Director, Academic Teaching Clinics (vacated December 2018)
Dr. Maeve O’Beirne – Director, Academic Teaching Clinics (December 2018)
Mr. Scott Jalbert – Team Lead, Quality and Informatics

DFM Academic Teaching Clinics



Primary Healthcare Collaborative

Primary Healthcare Collaborative (PHCC) case manager nurses are in place at both Sunridge Family Medicine Teaching Clinic (SFMTC) and Central Family Medicine Teaching Clinic (CFMTC). The nurses provide intensive case management for identified patients with complex psychosocial and medical needs, whose challenges overwhelm the resources offered by their medical home.

Case manager nurses received extensive training in community supports and resources, and work closely with the multidisciplinary clinical teams. They support patients through coordination of care, system navigation, and advocacy.

TeamStepps

The SFMTC participated in a pilot of the TeamStepps process, during which the clinic utilized several team development strategies.

A clinic team mission statement was developed: “We pride ourselves in our ability to work in teams to provide exceptional patient-centered care that is innovative and evidence-based

to the diverse population in our community, while training and mentoring future generations of healthcare providers”.

The clinic is currently partnering with the Alberta Medical Association (AMA) and Towards Optimized Practice (TOP) to pilot a Health Team Effectiveness Survey.

Resident Continuity Working Group

A multidisciplinary working group at SFMTC has focused on improving continuity between residents and patients, with several key initiatives for process improvement now in place. These include both patient and resident education about the importance of continuity and improvements in the appointment booking processes.

Initial data has shown improvement in both patient and resident experiences of continuity.

MD 24

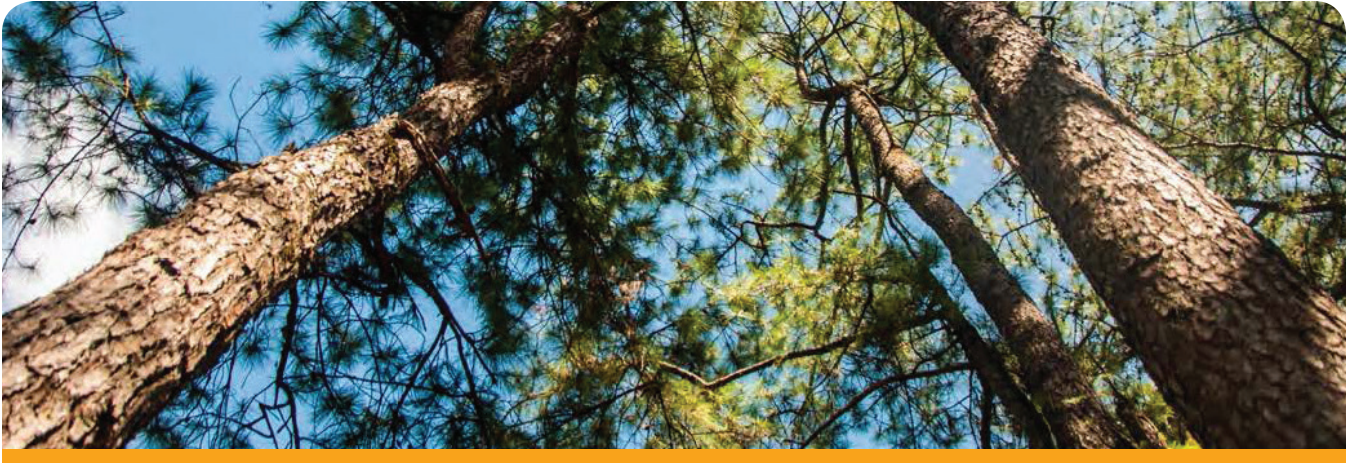
CFMTC introduced a new project to improve patientcentred care for complex patients. MD 24 provides enhanced access and an increased level of continuity of care for the medical home's more complex, vulnerable, or high-risk patients through partnerships with the Sheldon M. Chumir Urgent Care Centre and Health Link Alberta. The MD 24 goal is to deliver an expanded service model to smooth transitions from after clinic hours back to the medical home hours. MD 24 is currently operating in one of the four microsystem teams at CFMTC, with another microsystem to join in April 2019.

Enhanced Care Pathway

A number of patients at CFMTC have complex medical issues that require a high volume of services. Social determinants of health can have a great impact on how well a patient is able to manage their disease, and therefore how often the patient interacts with the health care system. Evidence-based tools were created to ensure that the patients' contexts were fully understood so that their health conditions could be better managed. Patients are then referred to the appropriate allied health professionals in the medical home.

These tools measure things such as food security, loneliness, anxiety/depression, and connectedness. AHS Volunteer Resources collaborate to recruit volunteers to go into the homes of the patients to help connect them with resources, and to gain understanding of the patient's living conditions. Volunteer home visits occur every two months for a total of three visits. Eighty patients have been enrolled so far.

Program evaluation is underway and will measure patient, provider and volunteer experiences, as well as patient use of ED/Urgent Care/ Hospital, and clinical measures of the control of the patient's conditions.



Supporting Vulnerable Populations

SFMTTC continues to support vulnerable populations in the community. The clinic is taking on privately sponsored refugees and those who have been discharged from the Refugee Program at the Mosaic Refugee Clinic.

The clinic has partnered with Arnika, an outpatient psychiatric clinic serving patients with intellectual disabilities and mental illness, to link unattached patients with family physicians at SFMTC upon discharge from the program. SFMTC is also working with the PCN Nurse Navigator at PLC to identify current inpatients who need a family physician in the community.

Targeted educational sessions have supported these initiatives, as well as additional education in the areas of transgender health and autism spectrum disorder.

Personalized Weight Assessment

A personalized approach to managing weightrelated issues is offered to patients that show interest by confirming through four questions that they are ready to change something now, related to their weight or weight-related health issue.A CFPCN Doctor of Pharmacy (Pharm D) student ran a pilot project to determine if patients were concerned about their weight. A questionnaire was given for a three week time period to every patient who participated. Over three weeks, the number of PWA referrals for assessment increased from one (on baseline, pre-measure) to the maximum of three patients per week.

Patient Reported Experience Measures

HQCA and CFMTC collaborated to survey over 1700 patients to better understand patient perspectives on the family medicine clinic. The survey was mainly conducted over e-mail and had over 50 questions to which 58% of patients responded, with 95% rating their experience at CFMTC as 'very good' or 'excellent'. Physicians were given personalized comments from the survey if there was a recognized opportunity for improvement from HQCA for their clinic. CFMTC plans to run Patient Reported Experience Measures (PREM) every 18 months with the next survey scheduled for June 2019.

Health Management Team

The team at SHCFMTC developed an approach to health management within the context of the medical home. Initially, this included opportunistic foot checks for diabetic patients and has evolved to include the non-diabetic patient population as well.

The team consists of the patient, nursing staff, allied health, and physician/residents collaborating on a patient visit. During the visit, the clinic team will perform foot checks if warranted, a medication review, and education as needed or requested. The team reviews a patient-focused care plan and discusses the patient's goals and their stated needs. Care providers work with the patient to develop a health plan based on their personal goals. Follow-up is offered and scheduled based on the visit results. At the conclusion of this discussion, the patient and the team members meet with the physician to review outcomes and plan accordingly.

ASaP+

ASaP+ is a collaboration between the SHCFMTC, South Calgary PCN, and TOP that seeks to strengthen existing processes in managing modifiable lifestyle factors. It focuses on supporting patients with their own lifestyle action plans and referrals to established community programs to empower them to make positive lifestyle changes.

Using various tools and strategies, it provides flexible care plans which support primary care teams to address, document, and follow-up on lifestyle discussions around alcohol and tobacco use, physical inactivity, eating habits, and weight management resources.

Primary Care for Transgendered Patients

SHCFMTC has developed a collaboration with endocrinology for the care of transgendered patients. Data shows that many LGBTQ2S+ patients do not seek a medical home or relationship with a primary care provider.

Part of this collaboration included endocrinology facilitated clinic education with the team around care for transgendered patients. The team reviewed and revised the patient introduction form to use inclusive language and collect information that was pertinent to all patients. SHCFMTC has ensured the clinic environment is welcoming for LGBTQ2S+ patients; this work was completed in consultation and collaboration with the Patient and Citizen Innovation Council (PCIC).

Patient and Citizen Innovation Council

SHCFMTC's PCIC meets quarterly. Patient advisors play a significant role in the clinic and attend the staff, physician, and Clinic Improvement Team meetings regularly. Patient advisors attended the Quality Improvement Half Day this year and viewed the film Falling through the Cracks: Greg's Story, followed by a robust discussion about the role of the medical home in the health care system.

The SHCFMTC PCIC has developed a patient satisfaction survey for the clinic that has been in use for the past three years. This year, the clinic chose to utilize the HQCA Patient Experience survey that was also used at the CFMTC to gather and collate information on the patient experience. PCIC members have played a role in PMH information sessions that take place on the hospital Mainstreet.

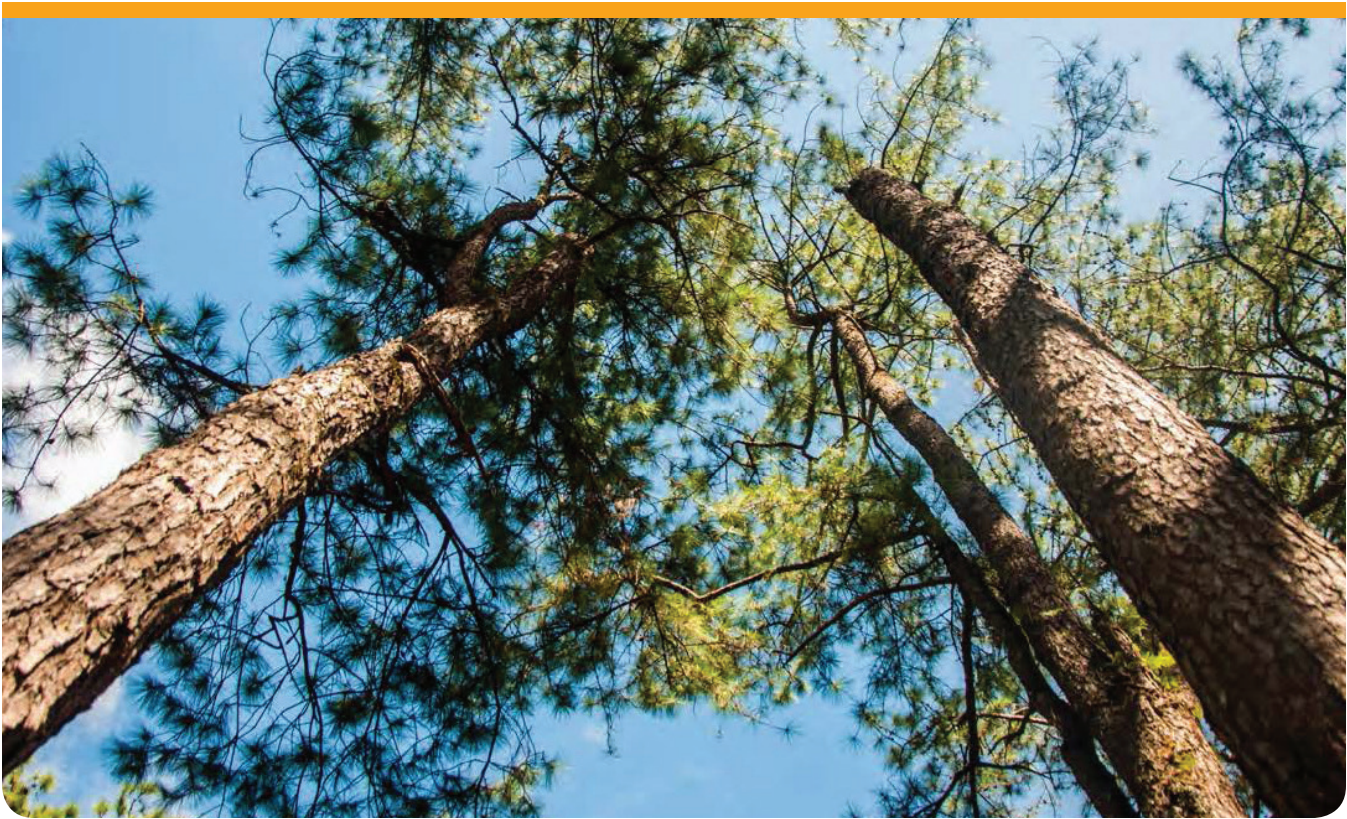
Rapid Access Unit Discharge
Collaboration Project

A pilot collaboration was initiated between the Rapid Access Unit (RAU) at South Health Campus (SHC) and SHCFMTC to improve care for patients at discharge.

Patients in need of a family physician who are admitted to RAU are asked if they are interested in SHCFMTC. If patients indicate interest, the RAU team contacts the SHCFMTC and provides access to current patient records. Introductory visits between the SHCFMTC physicians and health team and the patient are facilitated. At this visit, patient history is completed, a connection between the inpatient and community team is fostered, and the patient meets the clinic team and ensures they

are comfortable with the clinic and its processes. This collaboration allows for a smooth transition, including promoting further information sharing, such as test results that arrive after the patient is discharged.

Fourteen patients have been through the pilot and all are being followed through the clinic. Interviews were conducted to collect patient and provider feedback regarding the project. Long-term plans are to review administrative data to assess ED visits and hospital readmissions of patients involved in the project. The project was recently presented to SHC Site Leadership\ and there is potential to expand this collaboration to other units within SHC.



QUALITY & INFORMATICS

Dr. Maeve O’Beirne - Director, PMH and QI
Dr. Wes Jackson – Medical Lead, Advanced Technology and Informatics
Mr. Scott Jalbert – Team Lead, Quality and Informatics

Quality and Analytics Translation for the Medical Home: QuAnT-MH

QuANT-MH is the DFM’s new clinical metrics reporting tool. It is a standard visualization platform for clinical metrics that is user-friendly and easily accessed online.

This enables DFM leadership and individual physicians to make informed decisions based on metrics such as:

- Total patient visits
- Patient visits per half day
- Total physician panel size
- Complexity adjusted panel size
- Third Next Available (TNA)
- Physician level patient continuity
- Resident level patient continuity

There are new Alberta Screening and Prevention Program (ASaP) reporting tools for HbA1c, blood

pressure, and Body Mass Index. Each tool allows the individual accessing the dashboard to view metrics and information for every patient who has had the screening manoeuvre completed. The goal is to create a tool for each individual manoeuvre and examine trends with respect to practice, thereby increasing the screening rates of the manoeuvres and improving population health.

Partnering with the Canadian Primary Care Sentinel Surveillance Network (CPCSSN) extends the functionality within QuANT-MH to produce a comprehensive ASaP manoeuvres reporting tool. Physicians can evaluate ASaP-related practice goals and gain insight into research and panel-oriented questions for a multitude of related demographics, diseases, and test result distributions. This data is visualized through the online QuANT-MH dashboard.



Webicus

Webicus is a web-based scholarly activity dashboard providing a database and interface to store and report information related to research metrics. Webicus will allow for research and scholarship active physicians to evaluate their own statistics using an online

platform. Currently, Webicus is in the beta testing stage of the final product. The ability to provide information regarding publications, presentations, grant awards, and other scholarly activity to DFM faculty members is anticipated in spring 2019.

Dr. Martina Kelly – Undergraduate Education Director
Dr. Sonja Wicklum – Clerkship Program Director
Dr. Jimmy Vantanajal – Deputy Clerkship Director
Dr. Wendy Tink – Course Chair, Family Medicine Clinical Experience (MDCN 330 and 430)
Dr. Keith Wycliffe-Jones – Postgraduate Education Director (vacated October 2018)
Dr. Stephen Mintsoulis – Calgary Program Director (vacated March 31, 2019)
Dr. Keith Wycliffe-Jones – Interim Rural Program Director (vacated March 31, 2019)
Dr. Elaine Godwin – Rural Program Lethbridge Site Director
Drs. Saira Malik and Lena Derie - Gillespie – Rural Program Medicine Hat Site Co-Directors
Dr. Ron Spice – Rural Academic Director
Dr. Brendan Miles – Enhanced Skills Program Director
Dr. Marianna Hofmeister – Education Manager

Undergraduate Education

Undergraduate (UG) Family Medicine has started to transform the undergraduate curriculum to incorporate and reflect the principles of the Patient Medical Home (PMH). There is also significant effort to have increased family medicine representation on various medical school committees, thereby ensuring the family medicine perspective is heard throughout the continuum of the curriculum.

MDCN 330 and 430 continue to be flagship courses, offering learners opportunities to spend time with family doctors in their clinics. These courses are among the most highly rated by students and the program is grateful to community preceptors who are so willing to give of their time. Student feedback highlights how much they value having opportunities to spend time with patients but also the opportunity to network with preceptors, many of whom become mentors going forward.

This year, UG Family Medicine has focused on understanding if and how students learn about the PMH and this will become a key aspect of the curriculum going forward. UG aims to ensure that all students graduate with an understanding of the 10 pillars of the PMH, and ideally have clinical experience with this model of care. It is hoped that this will inspire students to recognize the central role of primary care and family physician leadership in advocating for improved community-based, accessible, comprehensive multidisciplinary care.

A significant challenge is planning for the new clerkship. The new family medicine clerkship will increase from six to eight weeks starting with the class of 2021. All students will now experience four weeks in an urban environment and four weeks in a rural environment. Additionally, all students will have experienced



FMIG Volunteers organize 'Project Warmth' clothing drive.

family medicine prior to making their Canadian Resident Matching Service (CaRMS) choice. The move to an eightweek clerkship will require more preceptors to welcome students to their clinics.

The Family Medicine Interest Group continues to be a source of inspiration as junior students host a number of events throughout the year to showcase family medicine as a career choice.



Postgraduate Education

The two-year Postgraduate (PG) Family Medicine Residency Programs greeted 70 residents in the Calgary Program and 14 in the Rural Program. A total of 16 residents joined the Enhanced Skills (ES) Program in July.

Overall, there are 223 residents across the program, with 172 in the Calgary Program, 35 in Rural, and 16 in ES.

The combined two-year programs graduated 93 new family physicians in 2018. Eighteen residents in the ES programs earned increased certification.

223 residents across the postgraduate program.

This was a year of major projects. The program embarked upon an Organizational Design Review in May 2018 with the following objectives:

1. To engage the program community to assess the current state for the purpose of program design.
2. To recommend a work system design based on the outcome of the organizational assessment.

Engagement activities included interviews, focus groups, and online surveys to gather input from Calgary and Rural Program preceptors, Calgary and Rural Program residents, program physicians, administrative staff, and external stakeholders.

The Design Team included a member from each representative stakeholder group and was responsible for reviewing data and advising on design criteria and concepts.

Some key recommendations resulting from this project include:

3. To recognize PG family medicine as one program with distinct cohorts and to reorganize the leadership structure as a matrix with unique program user groups and shared program functions with titles renamed to reinforce role awareness and clarity.
4. To propose simplified PG family medicine governance to enable stronger connections among people in the program giving them a stronger sense of belonging and ownership.
5. To propose a role description for the PG Program Director informed by design criteria and in alignment with accreditation standards.

Curriculum Mapping Project

Family medicine implemented competency-based medical education (CBME) in 2015 and quality improvement efforts are ongoing. The second major project undertaken this year was the curriculum mapping project. Significant effort was made to connect the entire PG academic curriculum to family medicine’s priority topics and identify gaps while connecting formal curriculum components to Entrustable Professional Activities (EPAs) and assessment.

PG dedicated significant energy to automating processes this year. The much-needed e-Assessment and curriculum mapping software development is in the initial stages with an anticipated launch later in 2019.

Continuing Professional Development

The Continuing Professional Development (CPD) program hosted 13 events that 120 preceptors attended. Grand Rounds occurs monthly on the second Thursday of most months with videoconference and teleconference connections throughout the province.

Fall Together, the annual DFM faculty development event, hosted 40 attendees who benefited from workshops focused on physician self-care, exercise prescriptions, providing narrative feedback, developing teaching strategies in a clinical setting, and redesigning the Family Medicine Clerkship at the University of Calgary.

To better support new clinical preceptors in the academic clinic, practice-based small group (PBSG) teaching sessions based on the Foundation for Medical Practice PBSG-ED modules were initiated. Approximately four sessions are planned per year. Two sessions have been already been completed.

Enhanced Skills Program

The eight ES programs are actively transitioning to CBME, which is a national and local priority for ES programs.

The College of Family Physicians of Canada will be creating a set of EPAs over the coming years for all category one programs. As all of the ES programs have developed - or are developing - EPAs, the University of Calgary is a national leader in this regard and believe the EPAs developed will inform the national dialogue.



RESEARCH & SCHOLARSHIP

Dr. Turin Chowdhury – Director, Research
Ms. Agnes Dallison – Manager, Research

The DFM focuses on four pillars of research:

- 1. Health Services
- 2. Medical Education
- 3. Indigenous Health
- 4. Health Equity

These four pillars are supported by the DFM Research Hub which coordinates with the Research Services Office (RSO), tracks and distributes funding opportunities, and provides conference poster support. Hiring research support is a major element of work in the Research Hub which coordinated support for over 20 research positions for this reporting period. Ethics support has been provided for 23 projects, including faculty and family medicine residents.

Budgeting and resources are sometimes unfamiliar topics for primary investigators (PIs) undertaking a new project. The DFM’s business coordinator is instrumental in coaching the PI and the newly on boarded staff in the current policies and practices for the DFM and to meet the requirements of funding bodies.

The Grant/Research Support Team (GReST) supports the researchers. This group consists of a research manager, business coordinator, communications coordinator, biostatistician, qualitative and quantitative methodologists, research coordinators, scientific editor, and administrative support.

Alberta College of Family Medicine Summit Awards

1st Place:
Under the Microscope: Examining the Quality of Primary Care EMR Data in Alberta
Stephanie Garies, Michael Cummings, Boglarka Soos, Neil Drummond, Donna Manca, Brian Forst, Kimberley Duerksen, Kerry McBrien, Hude Quan, Tyler Williamson

2nd Place:
Novel Normative Approach to Counting GPs - Are we Really That Off?
Terrence McDonald, Fiona Clement, Brendan Cord Lethebe, LA Green

3rd Place:
Support-FM: Supporting Family Physicians to Provide Community-Based Primary Care for their Patients
Amy Tan, Ron Spice, Aynharan Sinnaraja



Stephanie Garies accepts 1st place award at Family Medicine Summit



Dr. Amy Tan accepts 3rd place award at Family Medicine Summit

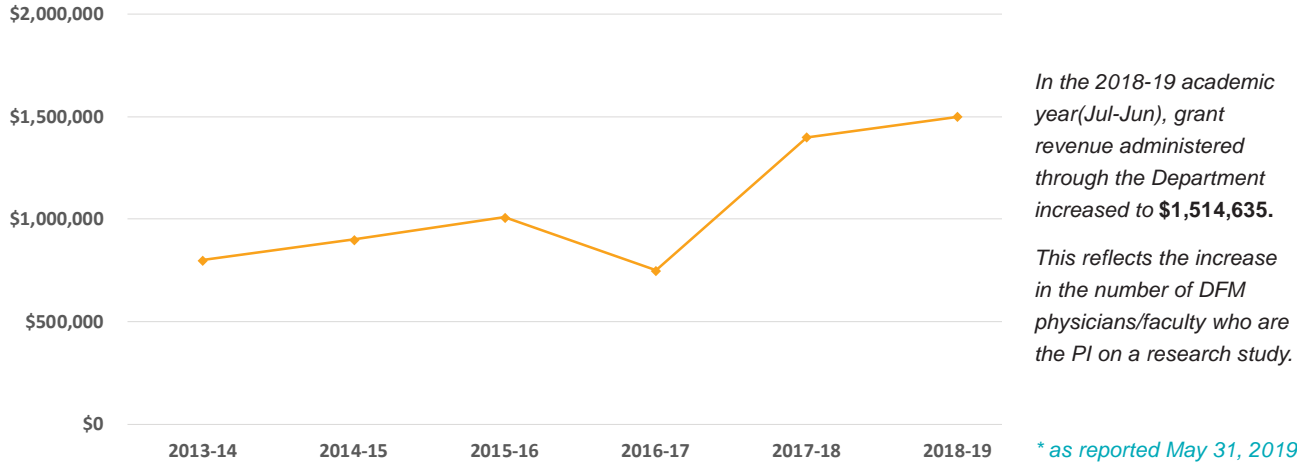
Scholarly Output

In the 2018-19 academic year (Jul 1-Jun 30), with data reported to May 31, 2019, DFM faculty and physicians with academic appointments with the department are credited with:

- Publications – **96**
- Presentations – **113**
- Grants – **26**, total awarded - **\$6,951,838** (based on fiscal year)

For a complete list of publications, presentations, and grants from July 1, 2018- May 30, 2019 including full citation information, see Appendixes

Annual PI Grant Revenue



Extra-Departmental Collaboration

Companion Animals and Older Adults: Exploring the Influence of Pets on Seniors’ Health Care Seeking Behaviours

Understanding how older adults’ health care seeking behaviours are influenced by their relationship with their companion animals is important for healthcare providers so that they can ensure that treatments and therapies prescribed are adhered to by their patients. This information helps health care providers further understand what obstacles, with respect to their pets, are present and are preventing elderly persons from accessing or seeking health care. In the summer of 2018, a veterinary medicine student, sought to identify potential areas of research as well as current key obstacles in Alberta health care settings so as to identify solutions that can be implemented from medical, veterinary, nursing, animal welfare, social services, and voluntary sector approaches.

The DFM has been involved in this work from a support perspective, with resources dedicated to expanding the knowledge base from a primary care perspective.

Perspectives of Primary Care Providers in Caring for Adolescents with Chronic Conditions Transitioning to Adult Care

This project had Research Hub resource and Departmental financial support and crossed over three faculties at the University of Calgary, including the Cumming School of Medicine, Faculty of Arts, and Faculty of Social Work. In addition, work continues in this area and the project is expected to lead to change in the way adolescents and their families connect with primary care as they transition to adulthood.

Community Health Navigation program puts Calgary patients in the driver’s seat

Navigating health care systems is not easy, particularly for patients with multiple chronic conditions such as hypertension and diabetes. There are numerous forms, tests, specialists, appointments all over the city, and clinical advice that can be difficult to understand.

That journey becomes even more arduous for someone who is new to Canada, whose English skills are poor, and who is not familiar with Calgary, public transit, or Alberta’s healthcare system. Dr. McBrien and her team have been working with the Mosaic PCN in Calgary to make life easier for patients, to improve their understanding of the system, the city, and the community supports that can help them manage their care.

With Mosaic, McBrien and the Interdisciplinary Chronic Disease Collaboration have developed a Community Health Navigation program in which ‘navigators’ assist patients with two or more poorly controlled chronic conditions: diabetes, hypertension, chronic kidney disease, heart diseases, Chronic Obstructive Pulmonary Disorder (COPD), or asthma.

Navigators help patients source everything from socialization programs at local community centres to exercise classes — in

some cases, they have taken classes together. If diet is an issue, navigators can connect people with the Food Bank, or tag along on trips to the grocery store to teach patients how to stretch their dollars for more nutritious meals. Ideal navigators are people who are from the community with shared experience. They do not offer clinical advice.

The program began as a pilot project with 27 patients at two clinics within the Mosaic PCN and in June 2018 expanded to 10 clinics, largely in northeast and southeast Calgary.

The work is being evaluated through a study called ENCOMPASS (ENhancing COMMunity health through Patient navigation, Advocacy and Social Support).

Thanks to Alberta Innovates and nearly \$1.5 million in funding through the 2018-19 Partnership for Research and Innovation in the Health System (PRIHS) competition, the program is expanding. The funding will allow McBrien and her team to test the model in other PCNs outside northeast and southeast Calgary to better understand the program’s effectiveness and whether it can be scaled across Alberta.



Photo by Michael Wood, O’Brien Institute for Public HealthFrom left: community health navigators Syeda Afreen and Suzanne Evanson, a third-year student in UCalgary’s Faculty of Social Work, with Rachel Clare, manager of the Community Health Navigation Services program at the Mosaic Primary Care Network, and Kerry McBrien, an assistant professor at the Cumming School of Medicine who helped develop the program. Kerry McBrien is an assistant professor in the Departments of Family Medicine and Community Health Sciences in the Cumming School of Medicine. (Credit to Michael Wood from the O’Brien Institute for this piece).



**APPENDIX A:
PUBLICATIONS**

1. Aghajafari F, Pond D, Catzikiris N, Cameron I. Quality assessment of systematic reviews of vitamin D, cognition and dementia. BJPsych open. 2018 Jul 01;4(4):238-249.

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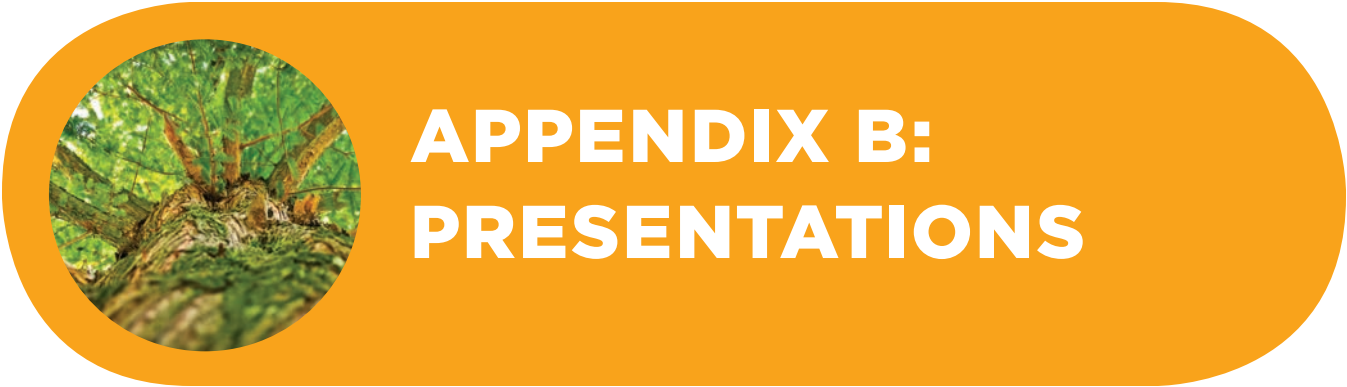
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56. Tan A, Spice R, Dunn S, Sinnarajah A. Supporting Family Physicians in Providing Community Based Primary Palliative Care. Oral Presentation at: 22nd International Congress on Palliative Care; 2018 Oct 4; Montreal, QC.

57. Tan A. Advance Care Planning & Other Medical-Legal Considerations for the Elderly. Rural Video Conference. Continuing Medical Education Office, University of Calgary; 2018 Nov 27; Calgary, AB.

58. Tan A. iCAN-ACP Primary Care: Outcomes of the Feasibility Pilot of the Implementation of an Adapted Serious Illness Conversation Guide Pathway at Sunridge Family Medicine Teaching Clinic (Calgary). iCAN ACP Project Webinar Presentation at: Department of Health Research Methods, Evidence and Impact, McMaster University; 2018 Sep 11; Calgary, AB.

59. Tan A. Symptomatic Management of the End Stage Patient within the Medical Home. Oral presentation: 43rd Annual Family Practice Review and Update Course Pearls for Practice. University of Calgary; 2018 Nov 20; Calgary, AB.

60. Turin T, Lasker M, Ferdous M, Chowdhury Z, Rashid R, Rahman N, Yeasmin F, Rumana N. Knowledge to Action strategy development town hall meeting with Bangladeshi-Canadian community: Identifying primary care access research priorities through community involvement. Poster presentation: North American Primary Care Research Group (NAPCRG) Annual Meeting; 2018 Nov 09; Chicago, IL.

61. Van Melle E, Wycliffe-Jones K, Schipper S, Holmboe E. Strategies for Designing & Implementing Your Competency Based Medical Education Program: An Introductory Workshop. Post-Conference Workshop at: International Conference on Residency Education (ICRE); 2018 Oct 21; Halifax, NS.

62. Wicklum S, Wiart S. The Women Warriors Program - an example of rural, indigenous, health promotion. Presented at: Meadowlake Tribal Council and Community; 2018 Oct 17; Meadowlake, SK.

63. Wicklum S, Wiart S. The Women Warriors Program - an example of rural, indigenous, health promotion. Presented at: Siksika Health and Wellness Conference, Blackfoot Crossing Historical Park; 2018 Oct 11; Siksika Nation, AB.

64. Wicklum S. The Women Warriors Program - an example of rural, indigenous, health promotion. Presented at: Parliamentary Health Research Caucus Reception, Northern and Rural Health Research in Canada, Centre Block, Parliament Hill; 2018 Oct 30; Ottawa, ON.

65. Witharana D. How to Help When Others Say They Can't: Practical tips for palliative and end-of-life care. Oral Presentation at: Practical Evidence for Informed Practice Conference; 2018 Oct 19; Edmonton, AB.

66. Wycliffe-Jones K, Moncrieff K. Using the Canadian Primary Care Sentinel Surveillance Network (CPCSSN) Database to Measure Patient Outcomes for Graduates of the University of Calgary Family Medicine Residency Program: A Pilot Study. Oral Presentation at: 2nd World Summit on Competency-Based Medical Education; 2018 Aug 24-25; Basel, CH.

67. Wycliffe-Jones K, Moncrieff K. Using the Canadian Primary Care Sentinel Surveillance Network (CPCSSN) Database to Measure Patient Outcomes for Graduates of the University of Calgary Family Medicine Residency Program: A Pilot Study. Oral Presentation: An International Association for Medical Education (AMEE) Conference. 2018 Aug 26 - 29; Basel, CH.

68. Wycliffe-Jones K, Schipper S. Questions about Teaching You Were Always Scared to Ask. Workshop given at: Family Medicine Forum (FMF); 2018 Nov 17; Toronto, ON.

69. Wycliffe-Jones K, Schultz K, O'Keefe D. Learn from our experience! Family Medicine Residency Program Directors share lessons learned about CBME implementation in Canada. Oral Presentation at: 2nd World Summit on Competency-Based Medical Education; 2018 Aug 24th-25th; Basel, CH.

70. Wycliffe-Jones K, Dufour K. Selection for Family Medicine Residency Training in Canada-Time for a conversation? Workshop at: CFPC Family Medicine Program Directors Retreat; 2018 Sep 25; Toronto, ON.

71. Wycliffe-Jones K, Schultz K, O'Keefe D. Avoiding potholes and Road-Blocks; Family Medicine Residency Program Directors share lessons learned about what works in successful CBME implementation. Lightning Round. Invited Workshop at: International Conference on Residency Education (ICRE); 2018 Oct 19 - 21; Halifax, NS.

72. Wycliffe-Jones K, Schultz K, O'Keefe D. Learn from our Experience! Family Medicine Residency Program Directors share lessons learned about CBME Implementation in Canada. Invited Workshop at: International Conference on Residency Education (ICRE)-Program Administrators Conference; 2018 Oct 18; Halifax, NS.

73. Yip S, Meyers D, Sisler J, Wycliffe-Jones K, Kucharski E, Elser C, Temple-Oberle, C, Spadafora S, Ingledew PA, Giuliani M, Kuruvilla S, Sumar N. Oncology Education for Family Medicine Residents and Family Physicians: A needs assessment survey. Oral Presentation at: Family Medicine Forum (FMF); 2018 Nov 14; Toronto, ON.

74. You JJ, Barwich D, Clark B, Gutman G, Howard M, Jayaraman D, Kaasalainen S, Kobewka D, Simon J, Sussman T, Swinton M, Tan A, Urquhart R, Winhall M. Improving Advance Care Planning for Frail Elderly Canadians. Workshop at: 22nd International Congress in Palliative Care; 2018 Oct 2 - 5; Montreal, QC.

75. Bailey L, Celis M, Gibson L, Bailey J, Ewa V. A Quality Improvement Project Using PAINAD to Improve Pain Management and Opioid Reduction in Persons with Dementia. Poster Presentation at: American Medical Directors (AMAD) Annual Post-Acute and Long-Term Care Conference; 2019 Mar 07; Atlanta, GA.

76. Butalia S, Lee R, McBrien K, Anderson T, Naugler C, Leung A, Quan H, Chen G, Lu M, Campbell D. Patient and Primary Care Provider Perspectives on Facilitated Relay to Enhance Use of Statins. Poster Abstract at: Canadian Association for Health Services and Policy Research; 2019 May 29; Halifax, NS.

77. Campbell D, Campbell r, Hwang S, McBrien K, Booth G. Characterizing program models for diabetes management among those experiencing homelessness. Oral presentation at: Canadian Association for Health Services and Policy Research (CAHSPR) Annual Meeting; 2019 May 29-31: Halifax, NS.

78. Campbell D, Lee R, McBrien K, Anderson T, Naugler C, Leung A, Quan H, Chen G, Lu M, Butalia S. Exploring patient and family physician perspectives on initiation and adherence to statin therapy. Poster Abstract at: Canadian Association for Health Services and Policy Research; 2019 May 30; Halifax, NS.

79. Coward S, Benchimol EI, Clement F, Hazlewood G, Kuenzig ME, McBrien K, Deardon R, Panaccione R, Seow CH, Windsor JW, and Kaplan GG. The Incidence of Inflammatory Bowel Disease: Analyzing Historical Trends to Predict the Future. Oral presentation at: Crohn's & Colitis Foundation and the American Gastroenterological Association. 2019 Feb 8; Las Vegas, NV.

80. Crowshoe L. CRA Indigenous Health Initiative: Integrating social and cultural contexts of care for Indigenous Patients with RA. Oral Presentation at: CRA & AHPA Annual Scientific Meeting; 2019 Feb 27; Montreal, QC.

81. Crowshoe L. Educating for Equity (E4E). Oral Presentation at: Indigenous Advisory Circle of the Diabetes Action Canada SPOR Project; 2019 Mar 20; Calgary, AB.

82. Crowshoe L. Educating for Equity (E4E): A Framework to Build Social and Cultural Confidence in Providing Care. Oral Presentation at: CRA & AHPA Annual Scientific Meeting; 2019 Feb 28; Montreal, QC.

83. Decker K, Popadiuk C, Blake J, Dickinson JA. Perspective on screening women under 25 years of age. Oral Presentation at: Pan-Canadian Cervical Cancer Screening Network Meeting; 2019 Feb 4; Toronto, ON. Performance for the Detection of Bacteria in Children Presenting in the Emergency Department with Acute Gastroenteritis. Oral Presentation at: Pediatric Academic Societies (PAS); 2019 Apr 1; Baltimore, MD.

84. Doig C, Walker I, Greer G, Myhre D. Beyond GPs, MCAT scores, MMIs, and aspects of randomness: In pursuit of increased equity in the medical school admissions process at the University of Calgary. Poster Presentation at: Canadian Conference on Medical Education (CCME); 2019 Apr 13-16; Niagara Falls, ON.

85. Ewa V, Defina R, O'Beirne M. Medical Education in the Long-Term Care Environment: Exploring residents' experience of learning in this environment. Poster Presentation at: American Medical Directors (AMAD) Annual Post-Acute and Long- Term Care Conference; 2019 Mar 07; Grapevine, TX.

86. Garcia-Jorda D, Ritter-Rattray C, Kamran H, Polachek A, McBrien K, Fabreau G. A Novel Program to Coordinate Care for Socially Vulnerable Individuals with Complex Health Needs: evaluating structure and processes of Connect 2 Care.

87. Poster Presentation at: Society of General Internal Medicine Annual Meeting; 2019 May 9; Washington, DC.

88. Henderson RI. Patient and Provider Empowerment through Critical Education around Structural Drivers of Diabetes in Indigenous People; Insights from the Educating for Equity Project. Presented at: The Northern Ontario School of Medicine, Division of Human Sciences Seminar Series; 2019 Jan 10; Thunder Bay, ON.

89. Howard M, Bernard C, Slaven M, Tan A, Barwich D, Klein D, Heyland DK. Primary Care Physician's Confidence, Willingness and Participation in Advance Care Planning Discussions: a Multi-Site Survey. Oral Presentation at: International Advance Care Planning (ACP-i) Conference; 2019 Mar 13-16; Rotterdam, NL.

90. Kamran H, Kennedy G, Rondeau K, Fabreau G, McBrien K. Using the Residential Time-line follow-back method to ascertain residential stability in Connect 2 Care clients. Poster Presentation at: AB SPOR Summer Institute; 2019 May 13; Edmonton, AB.

91. Kelly M, Vong V, Edge J. Is it a building? Assessing medical student's knowledge of the Patient's Medical Home (PMH): A Qualitative Study. Poster Presentation at: FM Summit; 2019 Mar 1; Banff, AB.

92. Kelly M. Blue Sky Thinking in FM Clerkship. Workshop presented at: Cabin Fever; 2019 Feb 9; Banff, AB.

93. Kelly M. Just coughs and colds: Medical students' perceptions of intellectual stimulation in family medicine. Oral presentation: What's Up Doc? Research showcase workshops: Family Medicine Summit; 2019 Mar 1; Banff, AB.

94. Kelly M. Learning with our senses. Oral presentation at: Master Teacher Retreat; 2019 Jan 17; Calgary, AB.

95. Koppula S, Lee S. My iPad Weighs Less Than Your Textbook and Other Intergenerational Musings. Oral Presentation at: Alberta College of Family Physicians' Family Medicine Summit; 2019 Mar 01; Banff, AB.

96. Lee S, Koppula S, Mintsioulis S, Topps M, Jacobs S. Clinical Learning Experiences and Resident Gender. Presentation at: OHMES - Health and Medical Education Scholarship Symposium; 2019 Feb 20; Calgary, AB.

97. Lindsay C, Ana R, Rita H. Confronting Healthcare Implications of Racism for Indigenous Peoples. Oral Presentation at: Alberta College of Family Physicians annual Family Medicine Summit; 2019 Mar 2; Banff, AB.

98. Liu X, Shahid R, Bertazzon S, Waters N, Patel A, Barber C, Faris P, McDonald T, Seidel J, Sharma R, Briggs T, Marshall D. Exploratory spatial analysis of comorbidities prevalence in people with osteoarthritis. Invited Speaker at: Proceedings of the 7th Conference on Spatial Knowledge and Information Canada (SKI2019); 2019 Feb 23; Banff, AB.

99. Makhdoom S, Mazloun G. Rural Obstetrics - Where Are We Now? Oral Presentation at: Rural Videoconference Series; 2019 Jan 22; Calgary, AB.

100. Malhi R, Myhre D, Ornstein J. The Impact of Rural Rotations on Urban Based Postgraduate Learners: A Literature. Oral presentation at: 5th Office of Health & Medical Education Scholarship Symposium; 2019 Feb 20-21; Calgary, AB.

101. McBrien K, Garcia Jorda D, Kamran H, Bertrand A, Fabreau G, Milaney K. What impacts success? A qualitative study of the structure of the Connect 2 Care (C2C) program. Poster Presentation at: Canadian Association for Health Services and Policy Research (CAHSPR) Annual Meeting; 2019 May 29-30; Halifax, NS.

102. McDonald T, Green L, Lethebe C, Seidel J, Patel A, Cook L, McBrien K, Bailey A. High Volume GPs and Health Outcomes in Alberta. Invited Speaker at: Proceedings of the 7th Conference on Spatial Knowledge and Information Canada (SKI2019); 2019 Mar 01; Banff, AB.

103. McDonald T, Clement F, Lehtebe C, Green LA. A Novel Normative Approach to Counting GPs - Are We Really THAT Off? Family Medicine Summit, Alberta College of Family Physicians; 2019 Mar 01; Banff, AB

104. McDonald T, Green L, Lethebe C, Seidel J, Patel A, Cook L, McBrien K, Bailey A. High Volume GPs and Health Outcomes in Alberta. Invited Speaker at: Proceedings of the 7th Conference on Spatial Knowledge and Information Canada (SKI2019); 2019 Mar 01; Banff, AB.

105. McDonald T, Lethebe C, Ronksley P, Seidel J, Patel A, Cook L, McBrien K, Bailey A, Green L. High Volume GPs and Health Outcomes in Alberta. Oral Presentation at: Canadian Association for Health Services and Policy Research (CAHSPR) Annual Meeting; 2019 May 29-30; Halifax, NS.

106. Moncrieff K, Wycliffe-Jones K. Using the Canadian Primary Care Sentinel Surveillance Network(CPCSSN) to measure patient outcomes for graduates of The University of Calgary Family Medicine Residency program; a pilot study. Oral Presentation at: Health & Medical Education Scholarship Symposium; 2019 Feb 21, 2019; Calgary, AB.

107. Myhre D, Malhi R, Ornstein J. The Impact of Rural Rotations on Urban Based Postgraduate Learners: A Literature Review. Oral presentation at: Alberta College of Family Physicians Annual Meeting; 2019 Mar 1-3; Banff, AB.

108. Myhre D, Malhi R, Ornstein J. The Impact of Rural Rotations on Urban Based Postgraduate Learners: A Literature Review. Oral presentation at: Canadian Conference on Medical Education (CCME); 2019 Apr 13-16; Niagara Falls, ON.

109. Nixon L, Marlinga J, Hayden KA, Mrklas K. Barriers Effective, Facilitators and Effective Interventions to Increase Primary Care Provider Prescribing of Opioids Agonist Therapy (OAT): A systematic review. Poster Presentation at: Family Medicine Summit; 2019 Mar 1; Banff AB.

110. Henderson R. Systems Thinking for Transformative Research: Disrupting the Health Inequities Landscape. Invited speaker for: Methods for Change: Knowledge Co-Creation Across Disciplines & Sectors World Cafe; 2019 Mar 15; Calgary, AB.

111. Tan A, Bernard C, Slaven M, Howard M, Elston D, Heyland DK. Examining Patient-Reported Barriers to Talking about Advance Care Planning (ACP) with Family Physicians: A Multi-Site Survey. Oral presentation at: International Advance Care Planning (ACP-i) Conference; 2019 Mar 14; Rotterdam, The NL.

112. Tan A, Paterson C, Bernacki R, Urquhart R, Barwich D, Howard M. 'While my thinking is clear': Outcomes from a feasibility pilot of a multidisciplinary, step-wise pathway for ACP in Family Medicine. Oral presentation at: International Advance Care Planning (ACP-i) Conference; 2019 Mar 14; Rotterdam, The NL.

113. Tarr GAM, Chui L, Lee B, Pang X-L, Nettel-Aguirre A, Ali S, Vanderkooi OG, Berenger B, Dickinson JA, Tarr PI, Kim K, Freedman SB. Guideline Performance for the Detection of Bacteria in Children Presenting in the Emergency Department with Acute Gastroenteritis. Oral Presentation at: Pediatric Academic Societies (PAS) Meeting; 2019 Apr 24; Baltimore, MD.

114. Weaver C, McBrien K, Sajobi T, Ronksley P, Williamson T. Machine learning for clinical prediction: for which problems might it be most useful? Poster presentation at: Canadian Association for Health Services and Policy Research (CAHSPR) Annual Meeting; 2019 May 29-30; Halifax, NS.



APPENDIX C: GRANTS

1. Armson H, Stang A, Burak K, Duncan D, Rivera L. Audit and Group Feedback: What works for whom and in which context: A realist evaluation of the Calgary Physician Learning Program. 2018-2019. Office of Health and Medical Education Scholarship (OHMES), University of Calgary. \$10,000.
2. Crowshoe L, Henderson R, Tanguay R. Enhancing Primary Care Capacity for Evidence-Based & Community Oriented Opioid Treatment in Indigenous Contexts in Alberta: Feasibility & Scale-Up of a Telehealth Model for Suboxone ® Delivery . 2018-2021. Health Canada, Substance Use and Addictions Program (SUAP). \$713,564.
3. Crowshoe L, Henderson R, Leduc C, Barnabe C, Montesanti S, Tailfeathers E, Green M. IDEATE (InDigEnous heAlTh Equity) Network for Primary Health Care and Policy Research in Alberta. 2018-2019. Canadian Institute of Health Research. \$75,000.
4. Drummond N, Birtwhistle R. The implementation of a Data Presentation Tool in Primary Care Clinics to enhance the surveillance prevention and management of Chronic Disease. 2018-2020. Queen's University subgrant, Public Health Agency of Canada. \$18,141.
5. Drummond N, Tangri N. Optimal approaches to chronic kidney disease case funding in Indigenous communities: A cluster randomized clinical trial. 2018-2020. University of Manitoba Subgrant - Research Manitoba. \$94,500.
6. Henderson R, Crowshoe L, Healy B. Structural Drivers of Iatrogenic Opioid Misuse in Alberta First Nations: Understanding Prescribing Patterns to Address Medicine's Role in the Opioid Crisis. 2018-2021. Canadian Institute of Health Research. \$206,550.
7. Palacios Mackay M, Lee S, Wycliffe-Jones K, Leduc C, Ellaway R, Raman M, Norcini J, Pereira J. Seeking Constructive Alignment in Programs of Assessment (SCAPA). 2018-2020. Stemmler Fund. \$93,988.
8. Lun V. Preseason Values of the Sport Concussion Assessment Tool 5 and cervical spine, oculomotor and vestibule-ocular reflex function for university contact and collision sport athletes. 2018-2019. Canadian Academy of Sport and Exercise Medicine. \$10,000.
9. McBrien K. ENCOMPASS: Enhancing COMMunity health through Patient navigation, Advocacy and Social Support. 2018-2018. Alberta Innovates - Health Solutions. \$2,000.
10. McDonald T, Seidel J, Patel A, Zhu H, Bailey A, Green L. Health Outcomes and Family Physician Patient Volumes. 2018-2020. MSI Foundation. \$88,000.
11. Wicklum S, Henderson R, McBrien K, Crowshoe L, Wiart S, Pahtayken D, Oliver A, Sampson M, Robb D, McGuire A. Women Warriors - Getting Active, Rising Up - Expansion Project to Onion Lake Cree Nation and Calgary, AB. 2018-2020. College of Family Physicians of Canada. \$15,000.
12. Crowshoe L, Henderson R, Rame A. Indigenous voices for critical education. 2019-2021. Taylor Institute for Teaching and Learning. \$40,000.
13. Crowshoe L, Walker J. T18 Phase 2. 2019-2024. Canadian Consortium on Neurodegeneration in Aging. \$375,000.
14. Drummond N, Garies S, Greiver M. SPIDER: An approach to support primary care practices in optimizing the management of patients with complex needs. 2019-2021. North York General Hospital Subgrant - CIHR. \$86,071.
15. Henderson R, Crowshoe L, Tailfeathers E, Fox T, Cowan K. Evaluation of Interventions to Address the Opiod Crisis Non-pharmacological interventions in pain management. 2019-2020. Canadian Institute of Health Research. \$100,000.
16. McBrien K, Manns B, Fabreau G, Gleeson N. ENCOMPASS: Enhancing COMmunity health through Patient navigation, Advocacy and Social Support. 2019-2022. Alberta Innovates - Partnership for Research and Innovation in the Health System. \$1,491,078.
17. Nixon L, Burns V. Improving access to integrated health care and housing for older adults experiencing homelessness, addictions and mental health challenges. 2019-2020. University of Calgary; Department of Family Medicine. \$5,000.
18. Nixon L, Burns V. Improving access to integrated health care and housing for older adults experiencing homelessness, addictions and mental health challenges. 2019-2020. Brenda Stafford Centre on Aging. \$10,000.
19. Nixon L, Burns V. Improving access to integrated health care and housing for older adults experiencing homelessness, addictions and mental health challenges. 2019-2020. O'Brien Institute of Public Health. \$25,000.
20. Nixon L, Wylie M. Preparing to scale Peter Coyle Place: an integrated health, housing and social support innovation for older adults. 2019-2019. Seniors Health Strategic Clinical Network - Alberta Health Services. \$6,000.
21. Yang H, Henderson R, Healy B, Kopciuk K, Cheung W, Nelson G, Shea-Budgell M, Colquhoun A, Letendre A, Al-Attar H. Assessing cancer screening and outcomes among First Nations people in Alberta. 2019-2019. Canadian Institute of Health Research. \$99,864.



DEPARTMENT OF FAMILY MEDICINE

8th floor, Sheldon M. Chumir Health Centre
1213 4th Street SW
Calgary AB
T2R 0X7

www.calgaryfamilymedicine.ca



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