Appendix I

Accountability Report 2014-15

Department of Family Medicine
Faculty of Medicine & Dentistry
University of Alberta

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The Department of Family Medicine

VISION

Alberta has a well-integrated, primary-care-based health care system in which all have access to a family physician who provides timely, proactive, individualized, comprehensive and continuity care through an interdisciplinary team of healthcare professionals led by that family physician. That team practices evidence-based, patient-centered care, and uses its own data, dialog with its stakeholders, and published research to continuously improve its service, quality, and safety.

MISSION

The Department of Family Medicine at the University of Alberta exists to teach the discipline of family medicine for the future of practice, and to produce scholarly work that improves the practice of family medicine and primary health care. We will achieve this outcome by developing and demonstrating excellence in:

1. Training residents for team-based, systems-based, socially accountable patient care and leadership,
2. Providing high-quality education to, and role models for, medical students, and
3. Conducting and disseminating clinical, educational, epidemiological, and health services research that improves the teaching and practice of family medicine and primary health care.

CORE VALUES

We are a learning organization.

We seek constantly to improve how we do what we do for our learners, patients, communities, and other stakeholders, encourage and accept input from them, and use both our data and their feedback to improve.

We support a culture of accountability.

Our Mission and how we pursue it will be responsive to our stakeholders; we are responsible with resources allocated to us and transparent in how we use them.

We are committed to mission-focused innovation.

We are creative thinkers, producing high-quality academic work that we share freely with others, as well as welcoming what others have to share with us.

ACCOUNTABILITY FRAMEWORK

The department's strategic plan has been crafted to facilitate achievement of the Vision and Mission of the Department of Family Medicine. The core of the strategic plan consists of the *Accountability Framework.* This framework *is designed* to support the objectives of this department in the areas of Education, Research and Health Services. Key indicators for each objective are tracked to ensure progress towards achieving the stated objectives.

Education

Family Medicine Education is aligned with the Triple C Competency-based curriculum (competency-based, continuity of teaching and patient care, comprehensive and centered in family medicine). Much of the learning occurs in Family Medicine environments and assessment of learners has shifted to a focus on competency across a group of essential skills called Sentinel Habits and Clinical Domains as observed by the experts; their teachers.

Our strategic direction begins in undergraduate medical education where we provide high quality education for our medical students while role modeling the discipline of family medicine. It also goes beyond the continuum of residency to offer opportunities for licensed graduates to obtain advanced skills over and above the basic family medicine objectives in the Enhanced Skills program. Commitment to the continuous education of faculty and staff in the areas of teaching, research, clinical care and administration remains a priority for this department through our Faculty Development program.

Table 1: Resident Continuity

S1-Objective 1: **Provide a Triple C competency based curriculum (competency based, *continuity, comprehensive, centered in family medicine)***		**2013-14**	**2014-15**
Indicator 1: Percentage of residents achieving target continuity with patient panels			
i.	Total visits by residents during their residency	22,075	37,435
ii.	Patients with visits to same resident twice during their residency	16%	17%
iii.	Patients with visits to same resident three times during their residency	5%	6%
iv.	Patients with visits to same resident four times during their residency	2%	2%
v.	Patients with visits to same resident five times during their residency	1%	1%
vi.	Patients with visits to same resident six times during their residency	2%	1%
Indicator 2: Percentage of clinical half days spent with primary preceptor supervision		84.5%	87%

Table 2: Triple C Curriculum

S1-Objective 1: **Provide a Triple C based curriculum (*continuity, comprehensive, centered in family medicine)***		**2013-14**	**2014-15**
Indicator 3: Percentage of residents achieving * FieldNote targets (FieldNotes targets changed based on faculty and resident feedback; 2014-15 data based on 1 note per week – 50 notes per year)		61.7%	79.1%
Indicator 4: Total number of FieldNotes created over 12 month period		5245	8897
Indicator 5: Percentage of residents achieving a pass in the **CCFP** exam first time		96%	96%
Indicator 6: Percentage of FieldNotes across all Clinical Domains			
i.	Doctor-patient relationship / Ethics	12.6%	11.9%
ii.	Care of adults	33.6%	34.7%
iii.	Care of children and adolescents	11.8%	11.8%
iv.	Care of the elderly	8.3%	8.1%
v.	Care of the vulnerable and underserviced	4.1%	4.0%
vi.	Maternity Care	8.3%	8.2%
vii.	Palliative Care	2.2%	1.8%
viii.	Surgical and procedural skills	11.1%	12.1%
ix.	Not applicable	7.6%	7.0%
Indicator 7: Number of weeks of rotational experiences that occur in family medicine environments		37%	43%

*FieldNotes – the process of documenting a sampling of direct observations and feedback given across all clinical domains and sentinel habits. Notes are stored in an electronic format for ease of sorting, reflection and assessment. The intent is for the resident to have enough of a sampling of notes across all clinical domains and sentinel habits to show competency.

Table 3: Meeting Community Needs and Enhanced Skills

S1-Objective 2: **Provide opportunities for family medicine graduates to meet the needs of Albertans including the development enhanced skills**		**2013-14**	**2014-15**
Indicator 1: Practice location after completion of Residency and Enhanced Skills Program. *June 30, 2014 Graduating Class N=89*		New Metric	
i.	Practicing in Canada		100%
iii.	Practicing in Alberta		92%
ii.	Unknown		8%
Indicator 2: Applications to the Advanced Skills program		113	121
Indicator 3: Accepted Enrollment / Successful completion of Advanced Skills program.		15/16	14/14

Table 4: Knowledge Translation and Faculty Development

S1-Objective 3: **Foster knowledge translation of best practice and innovation in Family Medicine education *(Research indicators; based on calendar year)***		**2013**	**2014**
Indicator 1: Number of faculty presenting education workshops and presentations (*inconsistency in 2013 data)*			37
Indicator 2: Number of teaching faculty on national and international education committees		11	17
S1-Objective 4: **Provide educators with the opportunity to develop skills to keep up with evolving curriculum**		**2013-14**	**2014-15**
Indicator 1: Number of Faculty development sessions held		9	3
Indicator 2: Number of participants in Faculty Development sessions		97	185
i.	Number of Department of Family Medicine participants	94	173
ii.	Number of Community participants	New Metric	12
Indicator 3: Number of Faculty involved in producing education support documentation or products.		16	17

Table 5: Undergraduate Family Medicine Exposure

S2-Objective 1: **Use curricula aligned with Can-Meds and Can-Meds FMU to increase the number of University of Alberta medical students choosing family medicine.**	**2013-14**	**2014-15**
Indicator 1: Number of students matching to University of Alberta Family Medicine after Round 1 ***CaRMS***	37	39
Indicator 2: Number of student evaluations of the Longitudinal Clinical experience *(previously called Community-based experience*)rated as good to excellent	96%	96.5%
Indicator 3: Mean overall rating of the ***Family Medicine Clerkship*** program from the graduation survey as compared to the national average /5	3.9	4.2
S2-Objective 2: **Increase exposure of University of Alberta's medical students to modern, progressive Family Medicine**	**2013-14**	**2014-15**
Indicator 1: Number of weeks of ***Family Medicine electives*** year 3 and 4 provided by Department of Family Medicine faculty and preceptors	209	219
Indicator 2: Number of hours spent teaching undergrad courses by Department of Family Medicine faculty or preceptors	1024.75	1105
Indicator 3: Number of weeks spent coordinating undergrad courses by Department of Family Medicine faculty or preceptors	236	345
Indicator 4: Residents as teachers – Number of hours Residents spend teaching, OSCE's, TOSCE's	580	709

Research

The Department of Family Medicine at the University of Alberta is a leader in primary care health systems and medical education research. Our members cover a broad range of research topics and disseminate research findings through papers, books, manuals, presentations and workshops at local, provincial, national and international conferences. The research focus of this department is in conducting and disseminating research that improves teaching , the practice of family medicine and primary health care. Research data in this report is based on a January to December calendar year as opposed to all the other areas which are based on the July to June Academic Year.

Table 6: Research Activity (Grants & Publications)

S3-Objective 1: **Conduct research to improve primary care and medical education**	**2013**	**2014**
Indicator 1: Number of new research grants awarded **DoFM faculty are PIs or Co-Investigators on the grant and funding administered/held by University of Alberta **or** other organizations*	44	27
Indicator 2 : Total value of NEW grant funding *(actual dollars)* received and held by DoFM, University of Alberta *(total amount of new funding in account for year reported- e.g. if total grant = $100,000 but only $50,000 was received during 2014, only $50,000 is reported). [Information obtained from e-TRAC]*	$1,840,661.31	$559,132.12
Indicator 3: Number of grants in progress (*cumulative)* **DoFM faculty are PIs or Co-Investigators on the grant and funding administered/held by University of Alberta **or** other organizations*	23	54
Indicator 4 (a): Total value of grant funding NEW and IN PROGRESS (dollars) (*cumulative)* currently held by DoFM, University of Alberta in the year reported. (*Information obtained from e-TRAC. *Excludes U of A internally funded projects e.g. NAAFP, almost all summer studentships, other funding from within U of A)*	$4,833,557.21	$5,081,719.00
Indicator 5: Number of peer reviewed publications	82	78
Indicator 6: Number of non-peer reviewed publications	29	12
Indicator 7: Number of books and chapters published	3	**8**

Table 7: Research Activity (Research Findings)

S3-Objective 2: **Engage in the translation of research findings to inform on education and on policy in primary care**	**2013**	**2014**
Indicator 1: Number of presentations to policy makers, health professionals, stakeholders		
i. Oral Presentations *(excludes educational presentations such as faculty development, courses, etc.)(Peer reviewed)*	77	116
ii. Poster Presentations (research)	59	123
iii. Workshops	10	10
Indicator 2: Number of peer reviewed presentations (research: poster& oral)	146	252
Indicator 3: Number of knowledge translation products, tools, manuals produced	26	61
S3-Objective 3: **Expand research expertise**	**2013**	**2014**
Indicator 1: Percentage of research projects external collaboration, locally, regionally, nationally and internationally.	150	138
I. Local	68.7%	61.6%
II. Regional	10.7%	6.5%
III. National	17.3%	25.4%
IV. International	3.3%	6.5%
Indicator 2: Percentage of faculty with advanced degrees	55%	72.5% *(n=29)*
Indicator 3: Number of research summer students *(person months)n = X students*	16.5 months *(n=7)*	27.5months *(n=8)*
Indicator 4: Number of grad students, (*Masters, PhD, fellows, post-doctoral and independent study students)*	4	17
Indicator 5: Number of faculty who supervise fellows, graduate students, and independent study students	2	7
S3-Objective 4: **Influence the health research agenda in Canada**	**2013**	**2014**
Indicator 1: Number and descriptions of positions on research funding organization committees, ethics, review and advisory boards	See attached Appendix II	See attached Appendix II

Health Services

The vision of this department is to ensure our residents are part of a system that ensures all patients will have access to a family physician and a team of interdisciplinary healthcare professionals that provide proactive, timely, individualized, comprehensive and continuous care. We role model by evaluating our own data to continuously improve the evidence-based, patient-centered care we provide. Measurement and evaluation are critical components to building organizations where quality improvement is part of the common culture.

Access to primary care services when the patient needs them and continuity with their primary care physician or their team improves patient care, patient and provider satisfaction and ultimately lowers health care costs. We monitor panel sizes on a regular basis to ensure quality patient care while meeting the educational needs of our family medicine residents. Panels then form the basis for patient continuity of care. The following data is from our four academic teaching sites.

Table 8: Academic Teaching Site Delay Indicators

S4-Objective 1: **Improve access to healthcare**	**2013-14**	**2014-15**	**Target**
Indicator 1: Average time to 3rd next available appointment (days)			
Clinic A	5.2	4.9	5
Clinic B	3.5	4.6	5
Clinic C	4.3	4.6	5
Clinic D	4.3	7.1	5
Indicator 2: **Average cycle time of appointments (minutes from check in to check out)**			
Clinic A	54	52	35
Clinic B	58	60	35
Clinic C	56	56	35
Clinic D	48	56	35
Indicator 3: Average red zone time *(time spent with provider, in minutes)*			
Clinic A	30	27	20
Clinic B (No data)	N/A	N/A	20
Clinic C	30	33	20
Clinic D	25	33	20

Table 9: Academic Teaching Site Clinic Activity

S4-Objective 1: **Improve access to healthcare - continued**	**2013-14**	**2014-15**	**Target**
Indicator 4: Continuity rate of provider panel (% of patients seeing own provider)			
Clinic A	79%	79%	75%
Clinic B	80%	81%	75%
Clinic C	85%	86%	75
Clinic D	80%	76%	75
Indicator 5: Number of new patients accepted to practice			
Clinic A	213	242	
Clinic B	232	307	
Clinic C	178	154	
Clinic D *(working on building panels for new physicians in 2013-14)*	734	397	
Indicator 6: Average return visit rate / 12 month period			
Clinic A	3	3	
Clinic B	3.8	3	
Clinic C	3.1	3.1	
Clinic D	3.6	2.4	
Indicator 7: Panel size – patients seen in the past 3 years			
Clinic A	5515	5500	
Clinic B	3418	4403	
Clinic C	4575	4642	
Clinic D	4620	5017	
Indicator 8: Utilization of Primary Care Network allied health service professionals and programs (number of events)			
Clinic A	1900	1617	
Clinic B	772	663	
Clinic C	868	780	
Clinic D	52	21	

Table 10: Academic Teaching Site Practice Quality Improvement

S4-Objective 2: **Foster best practice and innovations in primary care**	**2013-14**	**2014-15**	**Target**
Indicator 1: Number of practice quality improvement projects / initiatives in academic teaching clinics.			
Clinic A	7	24	
Clinic B	12	10	
Clinic C	12	7	
Clinic D	n/a	21	

Table 11: Academic Teaching Site Health Screening Completion Rates

S4-Objective 2:
Foster best practice and innovations in primary care (continued)

Indicator 2:
Percentage of population health screening completion rates.

	Clinic A		Clinic B		Clinic C		Clinic D	
	2014	**2015**	**2015**	**2015**	**2014**	**2015**	**2014**	**2015**
Mammography	64%	74%	61%	73%	55%	56%	49%	84%
Pap Test	63%	62%	48%	52%	49%	42%	38%	44%
Blood Pressure	93%	66%	78%	79%	46%	48%	49%	58%
Plasma Lipid Profile(Female)	86%	76%	71%	70%	68%	63%	75%	72%
Plasma Lipid Profile (Male)	80%	75%	65%	69%	53%	65%	62%	63%
Colorectal Cancer Screening - Colonoscopy last 10 years or Sigmoidoscopy last 5 years or FIT test last 2 years	61%	60%	61%	66%	30%	50%	75%	54%
Diabetes Screen – One of Hemoglobin A1C or Fasting Glucose	56%	80%	32%	76%	50%	69%	54%	65%
CV Risk Calculation (Framingham) Males	4%	10%	14%	14%	5%	9%	9%	69%
CV Risk Calculation (Framingham) Female	6%	14%	21%	21%	8%	13%	8%	76%
Height once	73%	89%	66%	92%	55%	69%	52%	82%
Weight 1 year	43%	43%	40%	39%	30%	31%	35%	52%
Weight 3 year	75%	70%	69%	72%	57%	57%	57%	66%
Alcohol Screening 1 year	37%	37%	12%	30%	19%	22%	23%	46%
Alcohol Screening 3 year	67%	64%	23%	57%	52%	40%	24%	56%
Smoking 1 Year	40%	37%	34%	40%	31%	30%	34%	51%
Smoking 3 year	76%	71%	55%	62%	52%	56%	51%	66%
Exercise Assessment 1 year	34%	35%	27%	54%	13%	19%	23%	46%
Exercise Assessment 3 year	60%	63%	48%	67%	16%	28%	23%	56%

Note 1: Data shown above for screening rates uses only age and sex as the criteria for eligibility for each maneuver. It does not take into account patient preference or medical reason for not having a maneuver done. For this reason, a rate of 100% would be inappropriate.

Note 2: Reports were run on the clinics entire panel of active patients. **"ACTIVE**" is defined as having had a visit in the past 3 years (36 months).

Table 12: Academic Teaching Site Assessment of Chronic Illness Care

Part of the transformation of the teaching clinics to a Patient's Medical Home environment includes the management of patients with chronic illness using team based, systems based, evidence based care while promoting patient self-management of their illness. Our measurement tools adapted from the "Assessment of Chronic Illness Care, copyright 2000 by the MacColl Centre for Health Care Innovation, Group Health Cooperative, are a validated set of surveys which elicit the perspective of patients (PACIC) and the care team itself (ACIC) in assessing care given and received for chronic illness patients. For the 2014-15 year, all patients with diabetes were sent the survey. A response rate of 20 percent was achieved for a total of 215 patients. As for the team survey, a 92 percent response rate was achieved for a total of 123 team members. The table below contains a high level summary of the results. Application of the tool gives a far deeper dive into each of the summarized domains below.

Indicator 3a: **DFM ACIC Score (Assessment of Chronic Illness Care)** (Care Team Survey) NOTE: The team survey consisted of 34 questions related to the 7 domains . Domain summaries shown below. (n=123)								New metric for 2014-15)
Rating scale 1-11; **11 being actions fully implemented** **1 actions not present**	**Clinic A**		**Clinic B**		**Clinic C**		**Clinic D**	
		2015		**2015**		**2015**		**2015**
Average overall program Score		7.32		6.86		5.94		6.69
1. System Level focus on Chronic illness care		6.90		7.12		6.31		6.50
2. Community linkages between practice and community resources		7.59		7.60		6.67		6.96
3. Effective self-management support		7.45		6.92		6.09		6.51
4. Evidence-based decision support, guidelines, protocols, education		7.09		6.60		5.78		6.34
5. Practice level improvements that impact provision of care		7.97		6.96		6.02		7.16
6. Clinical information systems to support chronic illness care		7.15		6.69		5.44		6.95
7. Integration of the Chronic Care Model in all elements of chronic care		7.05		6.13		5.28		6.44

Indicator 3b: **DFM PACIC Score (Patients Assessment of Chronic Illness Care)** (Patient Survey) NOTE: The patient survey consisted of 26 questions about their care for their chronic illness. A clinic average of those responses is shown below. (n=215) Most responses were consistently in 3-4 range. All 4 clinics showed room for improvement in the area of patient self-management, linking patients with community resources, social supports and offering take home written information about their condition. All 4 clinics scored highest around "well organized practice" with a range of 4-4.3.								New Metric for 2014-15
Rating scale 1-5; 5 being "Almost Always", 1 being Almost Never"	**Clinic A**		**Clinic B**		**Clinic C**		**Clinic D**	
	2014	2015	2015	2015	2014	2015	2014	2015
Average patient score out of 5, 26 questions / domains of chronic illness care		3.29		3.35		3.23		3.45

Indicator 3C: PCN-E Readiness Assessment Score - To be reported for 2015-16								**New Metric 2015-16**
PCN-E Readiness Assessment Score								

Table 13: Leadership and advocacy in healthcare delivery policy and Education in Quality and Safety in primary care.

S4-Objective 3: **Demonstrate leadership and advocacy in healthcare delivery policy.**	**2012-13**	**2013-14**	**Target**
Indicator 1: Number of provincial, national and international committees or working groups affecting policy attended by faculty or senior staff.			
S4-Objective 4: **Educate and support in Quality and Safety in primary Care**	**2012-13**	**2013-14**	**Target**
Indicator 1: Number of information sessions given to clinics	3	0	
Number Information sessions for learners	2	4	

Appendix II

Faculty Members on Research Funding Organizations

Faculty Member	Type of Activity
Allan, GM	Coordinator & Lead Editor, Alberta College of Family Physicians, Tools for Practice Editorial Advisory Board, Canadian Family Physician
Bell, N	Member, Canadian Task Force on Preventative Health
Cave, Aj	Reviewer, HSRC Grant Reviewer, Government of Scotland Reviewer, Canadian Thoracic Society Grant Reviewer, CIHR Knowledge Research and Synthesis Grant Panel Chair, CIHR Knowledge Research and Synthesis Panel Chair, Primary Care Group, Pediatric Asthma Pathway Committee, Alberta Health Services
Chmelicek, J	Reviewer, Janus Continuing Professional Development Grants, CFPC
Drummond, N	Director, DementiaNET Research Group
Garrison, S	Director of Research for Vancouver Coastal Health
Green, LA	Member, Primary Health Care Steering Committee, Alberta Health Reviewer, The College of Family Physicians of Canada Murray Stalker Award
Grunier, A	Grant Panel Member, University Hospital Foundation Medical Foundation
Kolber, M	Associate Editor, Alberta College of Family Physicians, Tools for Practice
Koppula, S	Member, Primary Health Care Steering Committee, Alberta Health Reviewer, The College of Family Physicians of Canada Murray Stalker Award
Korwonyk, C	Associate Editor, Alberta College of Family Physicians, Tools for Practice
Manca, D	Chair, CPCSSN PESC Committee