DEPARTMENT OF FAMILY MEDICINE
FACULTY OF MEDICINE & DENTISTRY
UNIVERSITY OF ALBERTA

Department of Family Medicine Accountability Report 2009-2010

EXECUTIVE SUMMARY

The Department of Family Medicine 2005 – 2008 Academic Alternate Relationship Plan (AARP) continues to be on an extension cycle.

The goals of the AARP and strategic plans are aligned with the vision and mission of the Department. Our vision is to *excel at providing modern, innovative family medicine education, primary health care research and health information management. Our Department and its graduates will be effective agents of primary health care change in Alberta.* Our mission is *to educate medical students in the principles of primary care and the discipline of family medicine, to prepare future family doctors to provide comprehensive health care, to contribute to family medicine research and literature, and to develop and implement innovations to improve primary care services for the benefit of our communities.*

The work of the Department is performed by academic physicians, preceptors, family medicine residents, medical students and clinical and support staff in administrative offices, four academic family medicine centers (Grey Nuns, Misericordia, Northeast Community Health Center, and Royal Alexandra), contracted community health clinics and other urban and community family medicine practices. Their efforts contributed to our ongoing successes in the current AARP.

EDUCATION PROGRAM

Overall, the reportable actionable measures associated with the Education Program strategic plan show improvement in a number of areas from baselines established in 2007 and in the previous reporting period. Changes currently being implemented in the undergraduate and postgraduate programs will rectify some instances where performance showed a decrease. Table 1 shows a summary of performance by actionable measure. The numerals in each column indicate our performance for each element of the objective (increase, decrease, or unchanged). The column "No Data" includes situations where the baseline had not been established.

Table 1. Summary of Education Program performance

Actionable Measure	Increase	Decrease	No Change	No Data
S1-O1: Provide education and opportunities for our students and residents for comprehensive learning based on current thought and high caliber teaching				
M1: Expand, promote and facilitate the development of high quality medical educators	2		1	
M2: Promote and support the participation of Family Medicine educators at the Departmental, Faculty, National and International levels	2			
M3: Monitor the support provided to and the continuing development of all resources required to meet learners' needs	2	1	1	1
M4: Use tracking tools to target areas of improvement for our learners' educational experiences	80	51	30	4
M5: Maintain and enhance educator quality	3			
S1-O2: Provide the tools and opportunities for consistency in supervision				
M1: Facilitate a reciprocal learning community through evaluation of supervision at multiple levels	2			
M2: Expose medical students to family medicine clinical experience			2	
S1-O3: Provide learning opportunities based on the four principles of family medicine				
M1: Promote a full range of clinical skills across all levels of training				1
M2: Provide opportunity for learners to demonstrate critical thinking in making decisions		1		1
Total	**91**	**3**	**34**	**7**

In the 2009/2010 academic year, the Department was fortunate to contract teaching services with 197 community-based family medicine preceptors. Of these, 104 provided education to family medicine residents and 124 provided education to undergraduate medical students; 31 of the 197 preceptors taught learners at both levels.

RESEARCH PROGRAM

The Research Program has made numerous gains in associated actionable measures, most notably in the objective of expanding research capacity and enhancing research productivity..

Table 2. Summary of Research Program performance

Actionable Measure	Increase	Decrease	No Change	No Data
S2-O1: Expand research capacity				
M1: Increase the critical mass of researchers in family medicine	4	2	4	
M2: Enhance research activity	4		1	
S2-O2: Enhance faculty research capabilities				
M1: Provide research skills development activities to clinical and non-clinical faculty		1		
S2-O3: Enhance research skills of learners				
M1: Support learners' research skills development	2	1		
Total	**10**	**4**	**5**	**0**

HEALTH CARE SERVICES

The Health Care Services program progress has been hampered by a lack of funding for quality improvement initiatives. Despite this, progress has been made in some areas. In others, implementation of initiatives has occurred or is occurring in the 2009/2010 reporting period.

Table 3. Health Care Services program performance

Actionable Measure	Increase	Decrease	No Change	No Data
S3-O1: Meet patients' needs				
M1: Improve access to health care services	2	2	1	
M2: Increase patient satisfaction				4
S3-O2: Develop and implement innovations in patient care				
M1: Implement new ways to use EMR to improve patient care			1	
M2: Implement practice management program/TOP			1	
S3:O3: Demonstrate leadership and advocacy in health care delivery models				
M1: Increase collaboration with internal and external stakeholders in health care service delivery models			1	1
S3-O4: Educate and support faculty in organization issues in clinical practice				
M1: Increase knowledge of processes used by others				2
Total	**2**	**2**	**4**	**7**

GLOSSARY OF ACRONYMS

AFMC	Academic family medicine center
AIM	Access Improvement Measures
BEARS	Brief Evidence Assessment of Research
CaRMS	Canadian Resident Matching Service
COE	Care of the Elderly (Enhanced Program)
EMR	Electronic medical record
ESP	Education Support Program
FM-EM	Family Medicine-Emergency Medicine
ICC	Integrated Community Clerkship
IMG	International medical graduate
ND	No data
NECHC	North East Community Health Center, Academic Family Medicine Center
PCN	Primary Care Network
PGME	Postgraduate medical education
PQI	Practice Quality Improvement
TOP	Towards Optimized Practice
UGME	Undergraduate medical education

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1.0 INTRODUCTION

1.0 INTRODUCTION

Activities conducted by the Department of Family Medicine are guided by our strategic plan, vision and mission. The Department's strategic plan is comprised of three pillars: 1) Education, 2) Research, and, 3) Health Care Services. Additionally, each of these strategic pillars is supported by informatics technologies and governance.

The goals of the strategic plan are aligned with the vision and mission of the Department. Our vision is to *excel at providing modern, innovative family medicine education, primary health care research and health information management. Our Department and its graduates will be effective agents of primary health care change in Alberta.* Our mission is *to educate medical students in the principles of primary care and the discipline of family medicine, to prepare future family doctors to provide comprehensive health care, to contribute to family medicine research and literature, and to develop and implement innovations to improve primary care services for the benefit of our communities.*

This Accountability Report covers the period July 1, 2009 to June 30, 2010 and reports results of indicators described in the Department of Family Medicine Accountability Framework Summary document dated June 2009. Baseline data for most results reported were collected in 2007.

2.0 EDUCATION PROGRAM

2.0 EDUCATION PROGRAM

The overall strategic goal of the Education Program is to ***provide a solid foundation for maintaining and enhancing the continuity of learning***.

2.1 OBJECTIVE S1-O1

The first objective relates to the Department's ability to provide comprehensive learning opportunities for medical education students and family medicine residents.

S1-O1: Provide education and opportunities for our students and residents for comprehensive learning based on current thought and high caliber teaching

This objective has five actionable, or performance, measures associated with it. The first involves *development of high quality medical educators.*

All but one teaching faculty in the Department are involved with undergraduate education at various levels—from course coordination to small and large group teaching. Teaching faculty are supported by community preceptors and adjunct faculty. In 2009/2010, the Department paid 197 community-based family medicine preceptors for teaching undergraduate learners (124 preceptors) and family medicine residents (104 preceptors); 31 preceptors provided education at both levels.

The faculty who did not teach at the undergraduate level had a change in job description that precluded undergraduate teaching in the classroom or workplace.

In 2009 there was a decrease in the number of teaching faculty involved with postgraduate teaching but a small increase in the percentage. The majority of postgraduate education is patient-centered clinical teaching conducted by family physicians in family medicine clinics although there are a small number of lectures for residents.

The Department retained the two individuals with postgraduate training who joined the Department in 2008 to lead our medical education and health services research programs.

Table 4. High quality educators

Actionable Measure	Indicators	Baseline		2008/2009		2009/2010		Change
		#	%	#	%	#	%	
S1-O1-M1 Expand, promote, and facilitate the development of high quality medical educators	a. Number of teaching faculty teaching UG students	35	100.0	38	100.0	**39**	**97.5**	⇧
	b. Number of teaching faculty teaching PG residents	32	91.4	38	90.5	**37**	**92.5**	⇧
	c. Number and expertise of non-physician faculty teaching UG and PG learners	4	-	6	-	**6**	**-**	≠

The second actionable measure for the first objective is to *promote and support the participation of Family Medicine educators at the Departmental, Faculty, National and International levels.* In 2009, committee participation was broken down by program area and by local. Faculty representation on committees at all levels increased.

Table 5. Participation on education committees

Actionable Measure	Indicators	Baseline		2008/2009		2009/2010		Change
		#	%	#	%	#	%	
S1-O1-M2 Promote and support the participation of Family Medicine educators at the Departmental, Faculty, National and International levels	a. Number of teaching faculty on education committees in the Department and the Faculty of Medicine and Dentistry and the University of Alberta	33	94.3	32	80.0	**37**	**92.5**	⇧
	b. Number of teaching faculty on national and international education committees	ND	-	7	17.5	**11**	**27.5**	⇧
	Total	**33**	**94.3**	**39**	**97.5**	**48**	**100.0**	⇧

Table 6 shows the breakdown by program area and the number of faculty participating in education committees. There was significant involvement of faculty in education-related activities. In addition to the data below, the Department had representation on 4 UGME, 4 PGME and 1 FM-EM province-wide committees. (The number in brackets represents the number of faculty participating on each type of committee.)

Table 6. Education committee participation by program and type

Program	Level of Committee				
	Department	Faculty	University	National	International
UGME	41 (23)	10 (5)	3 (2)	4 (3)	
PGME	24 (16)	6 (4)		2 (1)	
FM-EM	1 (1)	2 (2)		1 (1)	
COE	6 (5)	2 (2)	1 (1)	1 (1)	
ESP	3 (3)				
Faculty Development	5 (3)				
TOTAL	**80**	**20**	**4**	**8**	**0**

The third performance measure regards the support of resources. This includes the number of learning sites where students and residents receive clinical training. A second indicator (number and type of teaching, administrative support and expert educational resources) was not measured previously nor currently as the indicator has not been adequately operationalized.

Table 7 shows changes by each level of learning site.

Table 7. Learning sites

Site	Baseline	2008/2009	2009/2010	Change
UG urban	31	39	**54**	⇧
PG urban	24	25	**25**	≠
ICC	4	5	**ND**	ND
UG rural	25	20	**29**	⇧
PG rural	26	19	**18**	⇩
Total	**110**	**108**	**126***	⇧

*Data were not available for the Rural ICC Program

The fourth actionable measure for the first objective is measured by weighting evaluation scores for rural and urban rotations. Scores were calculated for the three areas (Organization and Objectives, Teaching and Knowledge Resources, and Evaluation and Feedback) combined and individually. Scores for each question are shown in Tables 8 and 9.

Table 8. Rural rotation index scores

Statement/Area	Y3 Rural Baseline	2008/ 2009	2009/ 2010	Change
I was treated with respect	91.9	93.3	**91.2**	⇩
I was exposed to effective and collegial interaction with other health care team members	90.1	84.1	**88.6**	⇧
Supervision of my clinical activities was adequate to ensure patient safety	89.0	91.5	**90.3**	⇩
Supervision of my clinical activities was appropriate	88.2	89.6	**86.4**	⇩
I had frequent opportunities to apply what I had learned to relevant patient problems and clinical situations	88.1	86.0	**88.4**	⇧
Teaching, knowledge resources and clinical exposure: Total	**85.1**	**88.9**	**89.4**	⇧
Important contact and schedule information, course materials and policies were provided to me	84.7	81.1	**84.9**	⇧
Clinical encounter-based instruction	84.4	82.9	**82.4**	≠
Organization and objectives: Total	**84.0**	**82.0**	**83.7**	⇧
The learning objectives and professional behaviors expected of me were made clear	83.3	82.3	**83.0**	⇧
Evidence-based practice and reflective practice were taught and role modeled	81.4	81.1	**79.8**	⇩
Adequate knowledge resources were provided to achieve the learning objectives	81.2	86.6	**85.0**	⇩
I received regular, timely, pertinent and constructive feedback on my progress and behavior	78.3	75.6	**77.4**	⇧
Suggestions for achievable improvements were linked to the means to accomplish them	78.2	78.0	**78.7**	⇧
Evaluation and feedback: Total	**73.8**	**80.1**	**80.8**	⇧

Table 9. Urban rotation index scores

Statement/Area	Y4 Urban Baseline	2008/ 2009	2009/ 2010	Change
I was treated with respect	89.8	93.6	**96.3**	⇧
I was exposed to effective and collegial interaction with other health care team members	86.1	89.4	**89.8**	≠
Supervision of my clinical activities was adequate to ensure patient safety	88.3	91.5	**94.8**	⇧
Supervision of my clinical activities was appropriate	89.1	89.4	**92.4**	⇧
I had frequent opportunities to apply what I had learned to relevant patient problems and clinical situations	86.7	85.6	**87.4**	⇧
Teaching, knowledge resources and clinical exposure: Total	**84.7**	**89.9**	**92.1**	⇧
Important contact and schedule information, course materials and policies were provided to me	86.1	89.8	**88.7**	⇩
Clinical encounter-based instruction	84.3	83.5	**85.2**	⇧
Organization and objectives: Total	**85.5**	**86.6**	**86.9**	≠
The learning objectives and professional behaviors expected of me were made clear	84.9	86.9	**87.6**	⇧
Evidence-based practice and reflective practice were taught and role modeled	85.1	85.2	**86.0**	⇧
Adequate knowledge resources were provided to achieve the learning objectives	80.1	85.2	**84.9**	≠
I received regular, timely, pertinent and constructive feedback on my progress and behavior	78.1	83.5	**84.8**	⇧
Suggestions for achievable improvements were linked to the means to accomplish them	79.2	84.3	**85.0**	⇧
Evaluation and feedback: Total	**74.0**	**85.0**	**85.7**	⇧

Table 10 on the following page shows the change in postgraduate residents' evaluations of their rotations. The rotations are evaluated on two criteria: educational objectives and workload. Ideally, index scores for educational objectives are 80.0 or higher; lower scores mean the objectives are not being met while higher scores mean the objectives are more relevant, appropriate or met. For workload attributes, ideal index scores are around mid-range; scores lower than 50.0 mean the workload is lighter than adequate while higher scores mean the workload is heaver than adequate. Scores in red indicate a decrease in evaluation score while those in green represent an increase in the score since the previous year. Scores in normal typeface indicate no change. Differences of 0.05 or less are considered unchanged due to rounding and are identified by normal typeface.

Table 10. Postgraduate rotations evaluation scores

Rotation	Educational Objectives														Workload					
	Q1		Q2		Q3		Q4		Q5		Q6		Q7		Q8		Q9		Q10	
	2009/10	2008/09	**2009/10**	2008/09	**2009/10**	2008/09	**2009/10**	2008/09	**2009/10**	2008/09	**2009/10**	2008/09	**2009/10**	2008/09	**2009/10**	2008/09	**2009/10**	2008/09	**2009/10**	2008/09
CCU	72.9	75.5	79.7	81.7	73.4	71.6	74.0	76.0	58.1	61.5	91.8	91.3	90.3	90.4	54.1	54.3	63.3	59.8	52.2	52.1
ER	86.1	88.3	80.0	81.2	74.9	80.4	77.5	75.9	73.6	76.5	98.5	97.3	94.8	94.5	50.9	50.4	51.9	50.8	46.5	47.4
Family Medicine	93.0	89.2	78.5	80.7	83.3	82.2	79.0	72.7	67.2	66.5	98.4	97.3	95.3	95.1	48.9	50.4	44.9	42.6	47.9	46.7
Geriatrics	81.1	86.0	78.8	77.5	77.4	81.6	75.4	77.5	48.0	44.9	97.1	97.0	96.2	94.5	53.3	50.5	47.6	45.5	50.1	46.3
IM	80.7	84.1	82.7	81.0	74.6	78.7	75.9	75.7	55.9	59.9	92.9	95.0	90.9	89.0	63.5	56.4	63.3	61.1	53.5	53.0
Ob/Gyn	72.9	78.1	74.5	74.6	62.8	72.6	69.0	71.0	72.2	79.0	95.1	95.3	86.4	89.1	55.5	55.1	58.7	59.0	48.3	52.1
Palliative	74.5	82.9	79.1	80.0	72.4	81.4	79.1	78.7	40.5	49.1	92.9	94.7	93.5	96.2	45.5	46.8	48.5	45.7	48.4	46.8
PC Obs	80.7	86.8	75.9	76.3	78.8	77.8	75.9	71.6	75.9	71.0	96.1	97.4	89.4	89.5	49.0	48.6	52.9	48.0	43.2	47.1
Peds ER	88.8	88.5	78.2	77.4	78.2	79.8	79.7	78.4	63.6	69.2	98.4	97.1	91.0	90.4	47.3	41.8	49.1	50.9	45.9	48.3
Peds	70.0	66.7	72.0	69.8	64.2	67.9	72.0	65.6	56.1	62.3	93.5	87.3	82.5	82.1	50.0	46.8	42.5	57.1	53.5	51.3
Psychiatry	79.7	78.4	77.1	74.0	73.5	75.0	76.1	73.2	43.2	44.2	95.6	94.9	91.7	91.9	42.7	46.6	50.5	49.6	46.5	44.0
Surgery	65.6	68.2	77.1	70.4	61.4	61.4	71.8	58.9	65.5	65.2	94.2	90.0	84.8	83.2	56.8	53.6	65.6	61.4	61.7	56.4
Urban FM	94.5	91.8	82.1	84.7	83.1	81.1	76.6	72.9	71.7	78.5	99.5	97.2	96.8	97.2	54.9	52.3	46.0	45.6	50.0	44.1

Q1. How relevant was the clinical material to Family Medicine?
Q2. Was there enough clinical material?
Q3. How relevant was the Academic material to Family Medicine?
Q4. Was there enough academic material?
Q5. Was there sufficient opportunity to do procedures?
Q6. How appropriate as the responsibility level?
Q7. Were educational objectives met by this rotation?

Q8. Patient load
Q9. On-call schedule
Q10. Non-educational tasks

As shown in Table 11, the number of teaching faculty with graduate degrees increased slightly from the baseline. Of the 14 faculty with graduate degrees, one is specifically in the area of education, while the others are Master of Science (7), PhD (4), Master of Clinical Sciences (3), Master of Public Health (2), and Master of Health Services Administration (1).

The number of clinical and adjunct appointments is derived from the University record of clinical lecturers. The increase in clinical lecturers resulted from inclusion of care of elderly adjunct appointments.

Table 11. Educator quality

Actionable Measure	Indicators	Baseline		2008/ 2009		2009/ 2010		Change
		#	%	#	%	#	%	
S1-O1-M5 Maintain and enhance educator quality	a. Number of teaching faculty with graduate degree in education or degree with content relevant to medical education	12	34.3	15	38.5	**17**	**42.5**	⇧
	b. Number of clinical and adjunct appointments in family medicine for teaching faculty	-	-	-	-	**-**	**-**	-
	GFT	34	-	41	-	**40**	**-**	⇧
	Clinical lecturers and adjunct	ND	-	189	-	**420**		⇧

OBJECTIVE S1-O2

The second objective refers to supervision of students and residents.

S1-O2: Provide the tools and opportunities for consistency in supervision

Two actionable measures are related to this objective. First pertains to evaluation of supervision at the undergraduate and postgraduate levels.

The numbers in Table 12 show a breakdown of the supervision of students and residents by full-time Department teaching faculty and clinic preceptors at the University and at the academic family medicine centres. The increase in the first indicator is due to the inclusion of non-clinical teaching faculty in 2009/10 reporting for UG students.

Table 12. Supervision of undergraduate and postgraduate learners

Actionable Measure	Indicators	Baseline		2008/2009		2009/2010		Change
S1-O2-M1 Facilitate a reciprocal learning community through evaluation of supervision at multiple levels		#	%	#	%	#	%	
	a. Percent of all teaching faculty supervising UG students	20	64.5	20	62.5	**38**	**95.0**	⇧
	b. Percent of all clinical teaching supervising residents	36	100	41	100	**45**	**100**	⇧
	GFT	29	-	31	-	**35**	**87.5**	-
	Clinic preceptors	7	-	10	-	**10**	**-**	-

The second performance measure refers to exposure of medical students to family medicine. Three sessions of shadowing are now mandatory for first year medical students.

Undergraduate students in the clinical years are now required to attend academic half days. However, excused absences for illness or being at a rural site reduced the percentage of less than 100%.

Table 13. Exposure to family medicine

Actionable Measure	Indicators	Baseline	2008/ 2009	2009/ 2010	Change
		%	%	%	
S1-O2-M2 Expose medical students to family medicine clinical experience	a. Percent of undergraduate students attending shadowing in FM	-	100.0	**100.0**	≠
	b. Percent of students attending academic half days	-	99.0	**99.0**	≠

OJECTIVE S1-O3

The third objective pertaining to the Education program refers to the principles of family medicine:

1. The family physician is a skilled clinician
2. Family medicine is a community-based discipline
3. The family physician is a resource to a define practice population
4. The patient-physician relationship is central to the role of the family physician

The first indicator refers to observations. A tool for accurately recording and measuring residents' clinical activities was not developed to permit measurement of this indicator at this time.

Table 14. Observation of residents

Actionable Measure	Indicator	Baseline	2008/ 2009	2009/ 2010	Change
S1-O3-M1 Promote a full range of clinical skills across all levels of training		#	#	#	
	a. Number of recorded observations for residents	ND	ND	**ND**	-

The second actionable measure addresses student and resident critical thinking in making decisions. Undergraduate students work in groups and learn clinical reasoning in clinic under the direction of family physicians. Residents are required to complete educational reasoning projects as a requirement for first year of residency. In 2009/2010, 20 of the 71 first year residents did not complete the required four BEARS.

Table 15. Critical thinking in decision making

Actionable Measure	Indicators	Baseline	2008/ 2009	2009/ 2010	Change
S1-O3-M2 Provide opportunity for learners to demonstrate critical thinking in making decisions		#	#	#	
	a. Number and percent of clinical reasoning cases completed by students	ND	ND	**ND**	-
	b. Number and percent of residents demonstrating critical thinking	179	279	**264**	⇩

EDUCATION PROGRAM SUMMARY

Overall, the reportable actionable measures associated with the Education Program strategic plan show improvement in a number of areas from baselines established in 2007 and the 2008/2009 academic year. Changes currently being implemented in the undergraduate and postgraduate programs will rectify some instances where performance showed a decrease. Table 16 shows a summary of performance by actionable measure. The column "No Data" also includes situations where the baseline had not been established.

Table 16. Summary of Education Program performance

Actionable Measure	Increase	Decrease	No Change	No Data
S1-O1: Provide education and opportunities for our students and residents for comprehensive learning based on current thought and high caliber teaching				
M1: Expand, promote and facilitate the development of high quality medical educators	2		1	
M2: Promote and support the participation of Family Medicine educators at the Departmental, Faculty, National and International levels	2			
M3: Monitor the support provided to and the continuing development of all resources required to meet learners' needs	2	1	1	1
M4: Use tracking tools to target areas of improvement for our learners' educational experiences	80	51	30	4
M5: Maintain and enhance educator quality	3			
S1-O2: Provide the tools and opportunities for consistency in supervision				
M1: Facilitate a reciprocal learning community through evaluation of supervision at multiple levels	2			
M2: Expose medical students to family medicine clinical experience			2	
S1-O3: Provide learning opportunities based on the four principles of family medicine				
M1: Promote a full range of clinical skills across all levels of training				1
M2: Provide opportunity for learners to demonstrate critical thinking in making decisions		1		1
Total	**91**	**53**	**34**	**7**

3.0 RESEARCH PROGRAM

3.0 RESEARCH PROGRAM

The overall strategy of the Research program is to ***conduct innovative family medicine and medical education research.*** Three objectives measure progress toward this goal.

OBJECTIVE S2-O1

The first objective pertains to research capacity within the Department.

S2-O1: Expand research capacity

Two performance measures are related to this objective. The first one is the critical mass of researchers, measured by protected time for research activities. There was an increase in three levels of FTE allocated to research and research FTE overall. Higher research FTEs represent an increase in research capacity in the Department.

Similarly, the number of clinical faculty with research responsibilities has increased. In addition to faculty research, other smaller research activities are conducted by residents who are required to conduct Practice Quality Improvement projects.

Table 17. Research capacity

Actionable Measure	Indicators	Baseline	2008/ 2009	2009/ 2010	Change
S2-O1-M1 Increase the critical mass of researchers in family medicine		#	#	#	
	a. Amount of commitment to research and scholarly activity (aggregate FTE)	5.2	6.3	**6.75**	⇧
		Number of Faculty			
	≤0.10	24	26	**27**	⇧
	0.11 – 0.20	9	9	**8**	⇩
	0.21 – 0.30	0	1	**1**	≠
	0.31 – 0.40	0	0	**0**	≠
	0.41 – 0.50	0	0	**0**	≠
	0.51 – 0.60	2	3	**4**	⇧
	≥0.61	0	0	**0**	≠
	b. Number of clinical and non-clinical researchers				
	Clinical	31	34	**35**	⇧
	Non-clinical	4	7	**5**	⇩

The second actionable measure related to research capacity is the amount of activity conducted by family medicine researchers. The number of research grants faculty was awarded was unchanged. The number of projects increased indicating faculty continue to conduct a large amount of research projects.

The number of peer-reviewed publications increased by four publications and the number of non-reviewed publications increased by six. A publication does not include letters to the editor of newspapers, or conference programs. The totals do not include other publications including books, monographs, technical reports and other media.

Table 18. Research activity

Actionable Measure	Indicators	Baseline	2008/ 2009	2009/ 2010	Change
S2-O1-M2 Enhance research activity		#	#	#	
	a. Number of research grants awarded	23	29	**29**	≠
	b. Number of faculty as PIs and CIs				
	Projects with faculty as PI	39	33	**58**	⇧
	Projects with faculty as CI	61	64	**94**	⇧
	c. Number of peer-reviewed and non-reviewed publications				
	Peer-reviewed	54	45	**49**	⇧
	Non-reviewed	29	40	**46**	⇧

OBJECTIVE S2-O2

The second objective refers to research capabilities.

S2-O2: Enhance faculty research capabilities

One actionable measure pertains to this objective. The number of research skills workshops conducted by the Research Program decreased by one workshop.

Table 19. Research skills development

Actionable Measure	Indicator	Baseline	2008/ 2009	2009/ 2010	Change
S2-O2-M1 Provide research skills to development activities to clinical and non-clinical faculty		#	#	#	
	a. Number of research skills development workshops given by Research Program and attended	9	8	**7**	⇩

OBJECTIVE S2-O3

The third objective regards learners' research skill development.

S2-O3: Enhance research skills of learners

One performance measure is attributed to this objective. Research skills workshops and seminars include those conducted during the Departments research forum series (7), Family Medicine Research Day (16) and other presentations (11).

Table 20. Learner skill development

Actionable Measure	Indicators	Baseline	2008/ 2009	2009/ 2010	Change
S2-O3-M1 Support learners research skills development		#	#	#	
	a. Number of research skills seminars, workshops and lectures delivered	15	31	**34**	⇧
	b. Number of research projects and activities conducted by FM residents				
	Projects	59	66	**68**	⇧
	Activities	179	279	**264**	⇩

RESEARCH PROGRAM SUMMARY

The Research Program has made numerous gains in associated actionable measures, most notably in the objective of expanding research capacity and enhancing research skills.

Table 21. Summary of Research Program performance

Actionable Measure	Increase	Decrease	No Change	No Data
S2-O1: Expand research capacity				
M1: Increase the critical mass of researchers in family medicine	4	2	4	
M2: Enhance research activity	4		1	
S2-O2: Enhance faculty research capabilities				
M1: Provide research skills development activities to clinical and non-clinical faculty		1		
S2-O3: Enhance research skills of learners				
M1: Support learners' research skills development	2	1		
Total	**10**	**4**	**5**	**0**

4.0HEALTH CARE SERVICES

4.0 HEALTH CARE SERVICES

The overall strategic goal of the health services program of the Department is to ***provide safe and effective health care***.

Four objectives are measured in this program.

OBJECTIVE S3-O1

The first objective addresses access to health care at academic family medicine clinics.

S3-O1: Improve access to health care services

All academic family medicine centres underwent training in quality improvement to increase access to health care services (Access Improvement Measures, AIM).

Clinics track the time between when a request is made for an appointment to when an appointment is actually received. This is measured by checking the schedule once per week on the same day and time and finding the third next available opening for each physician. Numbers are determined by counting each day from that moment to the third next available appointment including week-ends and statutory holidays. The average varied from 4 days to 13 days with a range of 2 to 15 days.

Cycle time refers to the amount of time a patient is in the clinic for his or her appointment. This time begins when the patient arrives as the clinic to the time he or she leaves after seeing the physician and is only measured when a change is implemented.

Continuity is calculated by measuring the total number of panel patients attending the clinic for the month and the total number of panel patients seen by their own primary care physician.

Table 22. Access to health care

Actionable Measure	Indicators	Baseline	2008/ 2009	2009/ 2010	Change
S3-O1-M1 Improve access to health care services		#	#	#	
	a. Delay for appointment	ND	6 days		-
	Grey Nuns Average	-		**4 days**	⇧
	Grey Nuns Range	-		**2 – 8 days**	
	Royal Alexandra Average	-		**13 days**	⇩
	Royal Alexandra Range	-		**11 – 15 days**	
	Misericordia Average*	-		**8 days**	⇩
	Misericordia Range*	-		**3 – 14 days**	-
	b. Cycle time	ND	ND	**ND**	-
	c. Continuity rate	ND	79%		-
	Grey Nuns			**79%**	≠
	Royal Alexandra			**84%**	⇧
	Misericordia*			**69%**	-

*The Misericordia data are measures for only 4 of 5 physicians at the time.

The measurements for the second objective for meeting patients' needs are derived from patients' perceptions of service. Patient surveys were conducted annually at four academic family medicine clinics in 2007 and 2008. In response to a request by clinic staff, the timing of surveys for 2010 has been changed from early fall to November. Changing the timing of the surveys allows clinics and residents to establish their working relationship and allows staff to adjust to all the changes that accompany the beginning of the academic year.

OBJECTIVE S3-O2

The second objective relates to innovations in how health care is delivered to patients in our community.

S3-O2: Develop and implement innovations in patient care

Two actionable measures are used to guide our success in achieving the objective. First is the use of electronic medical record (EMR) systems. Physicians, clinic staff and residents are trained on EMR functionality. Of four academic family medicine centres, three had an EMR system with various levels of functionality and one clinic was paper-based. The fourth is coming on line in the fall 2010.

Table 23. EMR usage

Actionable Measure	Indicator	Baseline	2008/ 2009	2009/ 2010	Change
S3-O2-M1 Implement new ways to use EMR to improve patient care		**#**	**#**	**#**	
	a. Number of AFMCs using EMR to identify patients needing follow up care	3	3	**3**	≠

The second performance measure is to implement clinical guidelines promoted by the Alberta Medical Association. Although implementing TOP is not dependent upon having an EMR, one of the academic family medicine clinics did not embark on the program.

Table 24. Implementation of TOP guidelines

Actionable Measure	Indicator	Baseline	2008/ 2009	2009/ 2010	Change
S3-O2-M2 Implement practice management program/Toward Optimized Practice (TOP)		**#**	**#**	**#**	
	a. Number of AFMCs implementing TOP guidelines	3	3	**3**	≠

OBJECTIVE S3-O3

The third objective in health care services relates to leadership and advocacy.

S3-O3: Demonstrate leadership and advocacy in health care delivery models

Continuing to make health care delivery models effective means being current on new ways of doing things. One way to keep current is to increase collaboration with others who are developing, piloting and/or implementing new systems.

The indicator "health care service delivery initiatives" has not been operationalized so no data are reported in this period.

Primary Care Network (PCN) inclusion rates are measured as some initiatives are developed by PCN resources. Faculty also benefit from participation in PCNs such as access to resources that may not be available otherwise. All eligible clinical faculty are members of Edmonton West, Edmonton Southside, Oliver, Edmonton North or Westview PCNs.

Table 25. Health care service delivery models

Actionable Measure	Indicators	Baseline	2008/ 2009	2009/ 2010	Change
		%	**%**	**%**	
S3-O3-M1 Increase collaboration with internal and external stakeholders in health care service delivery models	a. Number of physician faculty participating in health care service delivery initiatives	ND	ND	**ND**	-
	b. PCN inclusion rates	74.2	100	**100**	≠

OBJECTIVE S3-O4

The final objective for health care services relates to being current with other new developments in clinical practice.

S3-O4: Educate and support faculty in organizational issues in clinical practice

One actionable measure is associated with this objective: Increase knowledge of processes used by others. The two indicators refer to AIM indicators meeting targets and number of Quality in Primary Practice (QuiPP) indicators. The AIM data are reported in S3-O3-M1. Due to lack of funding, the QuiPP program has been delayed and no indicators have yet been developed.

HEALTH CARE SERVICES SUMMARY

The Health Care Services program progress has been hampered by a lack of funding for quality improvement initiatives. Despite this, progress has been made in some areas. In others, implementation of initiatives has occurred or is occurring in the 2009/2010 reporting period.

Table 26. Health Care Services program performance

Actionable Measure	Increase	Decrease	No Change	No Data
S3-O1: Meet patients' needs				
M1: Improve access to health care services	2	2	1	
M2: Increase patient satisfaction				4
S3-O2: Develop and implement innovations in patient care				
M1: Implement new ways to use EMR to improve patient care			1	
M2: Implement practice management program/TOP			1	
S3:O3: Demonstrate leadership and advocacy in health care delivery models				
M1: Increase collaboration with internal and external stakeholders in health care service delivery models			1	1
S3-O4: Educate and support faculty in organization issues in clinical practice				
M1: Increase knowledge of processes used by others				2
Total	**2**	**2**	**4**	**7**