CROWFOOT VILLAGE

FAMILY PRACTICE

YEAR IN REVIEW

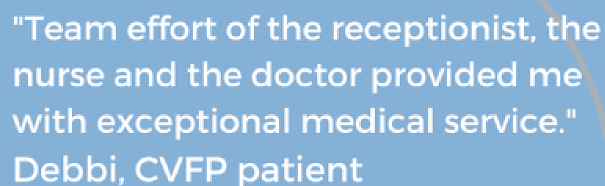
April 1, 2022 to March 31, 2023

SHARING THE **HALO**

We are very proud of our team-based care model; a model we have been continually improving.

We work together to support patients' needs delivered by five health teams - Gold, Silver, Green, Yellow and Blue. These teams include doctors, a nurse practitioner, registered nurses and medical office assistants. Pharmacists, respiratory educators, a health management nurse and a behavioural health consultant are also part of our clinic teams. Research supports many benefits to team-based care:

- Enhancing access to care and services
- Supporting quality improvement and reliability of care
- Promoting better health and functioning in those who have a chronic condition
- Impacting health system costs like emergency visits and in-patient hospital stays



Listen to Debbi's Story, CVFP Blue Team

LOOKING BACK, **PLANNING AHEAD**

2023 has been an interesting year in primary care full of reflection, learning and fostering connection with our team and patients.

As we emerge from the COVID-19 pandemic, we see shifts in both the needs of our team members and our patients. In 2022-23, we focused much of our energy in gaining a better understanding of those needs, and evolving practices and service delivery at CVFP.

Top of mind this past year was ensuring our patients had access to care in their medical home as wait times and system capacity have been impacted significantly since 2020. This included collaboration to streamline workflows with our team and in the electronic medical record to ensure patient care could continue to happen outside of a traditional visit. Since 2021, we have seen a 133% increase in secure email interactions with patients, a 20% increase in in-coming calls managed by our team, and we initiated trials with automated software for symptom screening and appointment confirmation as well as facilitating electronic prescribing. Patient medical needs are also evolving, many becoming more complex requiring care in the community as we wait for specialist supports; this necessitates an increase in long visits (30-minute appointments) to ensure we are providing fulsome care to the CVFP patient panel.

In 2022-23 we were fortunate to work closely alongside the team from Greg's Wings Projects as we aim to shift our focus from patient centred care to patient partnered care. This included project work with our Patient Experience Partner (PEP) Squad which includes approximately 170 CVFP patient volunteers who share their perspective, experience and feedback as they navigate the health system. Through a series of focus groups with our PEP squad, we worked to redesign our patient orientation program which included the development of a patient friendly guide, video introduction and patient orientation experience. The patient voice is critical in both the design and delivery of primary health care and we will continue to create and foster opportunities for this type of engagement.

As we look to the future, we explore ways to create capacity and access to the CVFP medical home for people in our community. The CVFP waitlist currently includes 4,400 patients from NW Calgary and the surrounding area who await attachment to a primary health team. We are currently exploring new professionals to add to the team that meet the health needs of our patients, and physician recruitment and innovation in service delivery to align with already existing supports in our community – like pharmacists. As we look to the 2023-24 year, we are excited about the opportunity to continue to evolve the patient's medical home, innovate care delivery and improve system capacity for our community.

PHYSICIAN **DEVELOPMENT**

The CVFP family physician development program continues to build and develop competent and capable, much needed family doctors for our communities.

In the summer of 2022, we graduated six new family doctors (two of whom continue to service the CVFP panel as a valued part of our team). We anticipate another six graduating in summer 2023, and are scheduled to welcome another eight new medical graduates in July 2023. Our residents help to provide the care our patients receive as a vital part of our team and we are grateful for their skills, new experiences and compassion.

"I am beyond grateful for the staff and physicians at CVFP. Thank you for always getting us in as quickly as possible. Thank you for the wonderful care you provide my family."
Pam, CVFP patient

Listen to Pam's Story, CVFP Green Team

We've been fortunate to have the company of some excellent medical students from the University of Calgary throughout the year. We are pleased to help them see how primary care should be delivered as part of a highly functioning health care system, while they develop broad medical diagnostic skills. We are so grateful to our patients who take the time to tell them their stories and allow them to develop their skills.

As we continue to look forward in physician development, in 2022 we welcomed Dr. Kathleen Young, one of our long-time physicians, to our formal postgraduate teaching team. She will be joined by Dr. Julie Croteau and Dr. Brooke Miller to regular teaching in July 2023, sharing in the supervision of a resident physician.

Our CVFP physician team remains deeply engaged with undergraduate and postgraduate medical education locally, as well as lending experience to the plans for the future of family medicine in Alberta and through the national college.

Dr. Ian Johnston, CVFP Family Physician and Teaching Lead

QI
INITIATIVES

Quality Improvement (QI) continues to be part of the CVFP culture. Projects that are successful become part of our routine day-to-day practices and every year we endeavour to find new ways to improve.

Hypertension Project

Our largest new project is directed at expanding our ability to screen, identify and treat high blood pressure/hypertension (HTN). HTN is a significant contributor to morbidity and mortality in Canada. We already have excellent management of our existing HTN patients through our multi-disciplinary team of pharmacists and nurses. As we come out of the crisis period of the COVID-19 pandemic, where virtual care was a higher priority, we realize that our screening rates have waned. We have created three working groups to focus on screening, diagnosis and treatment so that our process is stream-lined across the clinic and we have an agreed upon approach to care. A large component of this work is patient-partnered as we look to patients to hear what works for them and how they prefer to engage with us. Our goal is to provide relevant resources and support for patients to accurately measure and manage their own blood pressure.

QI
INITIATIVES

Virtual Diabetes Prevention Program

Diabetes carries a large burden to both patients and the health care system. The Virtual Diabetes Prevention Program (vDPP) was brought to our attention through our multi-disciplinary team. This program was a pilot project in partnership with Alberta Blue Cross; Primary Care Networks; and the Diabetes, Obesity and Nutrition Strategic Clinical Network. The program connected patients to coaching to promote lifestyle changes such as weight loss, healthy eating and physical activity. Eligible and appropriate pre-diabetic patients were identified by providers through our electronic medical records. These patients were then offered the vDPP program by our team which included a health management nurse and a multi-disciplinary team coordinator. Of the 475 eligible patients in our clinic, the program was offered to 152 patients. The program was cut short and ultimately 20 patients participated before it was closed down. Several of the remaining patients have been connected to other resources through our health management nurse.

FIT-based Screening

Given the modifications in the way we practice since the onset of COVID-19, our opportunistic screening had not been as high a priority as it was previously, with the goal of reducing provider and in-person contacts. While we have resumed some opportunistic screening, we feel it is important not to rely solely on opportunity to improve our screening rates. Our colon cancer screening rate was 70% back in March 2019 and is now 64%, still better than our PCN comparator colleagues, but with lots of room for improvement. We are using colon cancer screening as an anchor to review patients charts and offer all overdue screening. This is being done largely through secure email but also by telephone where the patient is not connected to our secure system. This will be spread over a year in order to minimize provider and administrative burden. We're hopeful that we can, at minimum, return to our previous screening rates and even improve on them.

QI
INITIATIVES

Other Projects

Once again this year, we have engaged with the Health Quality Council of Alberta (HQCA) for their patient experience survey. The surveys are completed and we are awaiting results. We continue to receive the HQCA Primary Healthcare Reports at both the provider and clinic-level which inform our quality improvement projects. We also stay connected with the Canadian Primary Care Sentinel Surveillance program participating in research and quality improvement projects.

Finally, as part of the teaching program, family medicine residents designed and completed several QI projects. Topics this year have included:

- Improving frequency of discussion in advance care planning
- Identifying and optimizing routine screening for patients with non-alcoholic fatty liver disease
- A qualitative project exploring patients who chose non-vaccination for COVID-19
- Assessment of a decision support tool for patients and providers regarding psychotropic medications
- Optimizing education for hyperlipidemia

Dr. Karen Seigel, CVFP Family Physician and QI Lead

"The Yellow Team and others I have met at CVFP are on top of everything when it comes to my health and they have the best way of delivering these services."
Mary Anne, CVFP patient

Listen to Mary Anne's Story,
CVFP Yellow Team

CVFP HEALTH **HOME**

The patient's medical home at CVFP continues to evolve.

We are gaining awareness around how to work in partnership with our existing patients and how to thoughtfully expand our capacity to care for people in our community. We look to empower patients with access to their health information through shared decision making, collaborative decision making, and involving family and patient supports in the journey. We continue to learn from patient experience to evolve care delivery. We look to expand our team to include additional health professionals best suited to the unique needs of our patient panel, and to innovate to look at ways to best use already existing professionals and resources in our community.

Team-based primary care is the foundation of a strong and sustainable health system for Albertans. We continue to strive for excellence through innovation, quality improvement, team development and a commitment to learning. We are proud to share our experience with our primary care colleagues and primary care leaders in Alberta.