DoM | DEPARTMENT of MEDICINE
Improving Lives

Department of Medicine 5-Year Strategic Plan

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Background

In late 2011 the Department launched a strategic planning process to help develop priorities for the next 5 years. A Departmental Committee was formed to oversee this process:

October-November	Facilitation support engaged and planning approach developed
December-January	Focus Groups administered and findings documented: • 4 with Internal Stakeholders in Halifax + 1 in Saint John • 2 with External Stakeholders
February-March	Focus Group findings analysed and discussed Approach to engaging Department members developed Retreat process designed
April	Preparatory materials posted for Department members to use in retreat preparation
May	Departmental Retreat at the Four Points Sheraton in Halifax. Analysis of Retreat findings to inform crafting of our Mission, Vision, Values and Strategic Priorities.
June	Endorsement in principle of the foregoing as the basis for development of Implementation Plans
September-December	Working Groups refine the input to date and recommend to the Strategic Planning Committee, Goals and Implementation Initiatives for Research, Education and Clinical Care.
January 16, 2013	The Departmental Executive Committee endorsed the 3 Strategic Goals and associated Implementation Initiatives as the basis for implementation of the Department's 5-year strategy and for presentation to the Department.

Strategic Planning Committee Members

David Anderson	Professor & Head, Department of Medicine, Dalhousie University District Chief, Department of Medicine, Capital Health
Ken Baird *	Capital Health
Ian Epstein	Gastroenterology
Simon Jackson	Deputy Department Head & member of the Cardiology Division
Lynn Johnston	Division Chief, Infectious Diseases
Heather Macpherson	Administrator Department of Medicine
Kathryn McIlrath	Physician Resource Officer
Christine Short	Division Chief, Physical Medicine & Rehabilitation
Stephen Workman	General Internal Medicine

* resigned following secondment April 1, 2012

Note: As indicated above, this flows from focus group work that informed a Departmental retreat attended by over 60 members. (A Summary Report for the Retreat can be found on the shared drive.) Three working groups and the Department's Strategic Planning Committee then built upon those foundations to generate what follows.

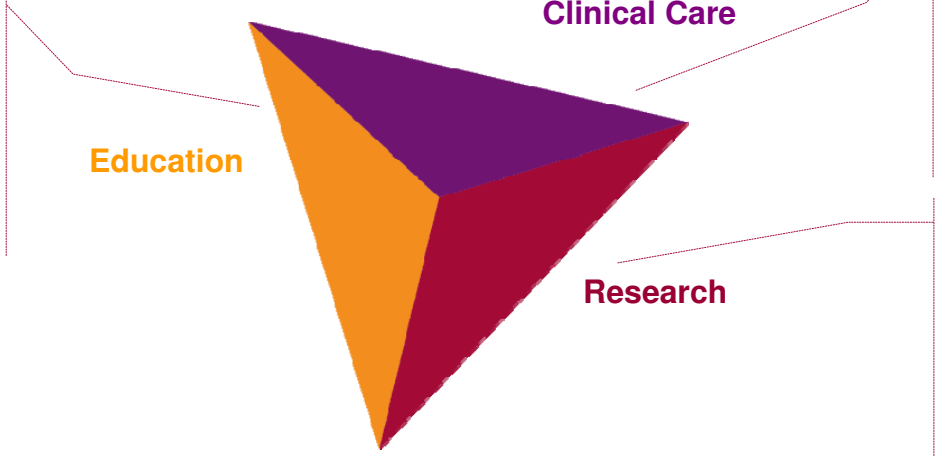
The Strategic Framework

Departmental Mission

We are a diverse group of highly trained professionals dedicated to improving health through education, research and providing exemplary clinical care to our community

Integrated Academic Vision

To be leaders in academic medicine providing innovative, collaborative and appropriate care that is sustainable



Attracting and growing the best.

▪ Continue to build a culture where clinician teachers are encouraged, evaluated, and acknowledged for excellence and innovation in education. ▪ Promote and lead educational initiatives across the continuum of medical education. ▪ Create the best internal medicine experience in Canada.

Leading quality care through innovation.

▪ Improve health care of frail patients with multi-morbidity and enhance their experience of required complex care while reducing or at least controlling per capita costs. ▪ Appropriately triage patients to tertiary, secondary and primary levels of care.

Driving research excellence.

▪ Grow a culture of scientific inquiry by generating excitement around research excellence such that all Department members are involved in or supportive of research. ▪ Identify and develop a research focus that complements the Department's clinical care and education activities.

Leadership	… exercising our responsibility as the Maritimes' largest academic unit to confidently provide direction and lead by example; advocating for and driving important change
Innovation	… becoming leaders in research and new care delivery models; being driven to make things work in different, better ways
Excellence/ Quality	… measuring and assessing the quality of our work with a view to being recognized for producing the best
Accountability	… being accountable and transparent in all that we do
Effectiveness	… being results oriented; deciding on and achieving priorities; and making significant things happen.
Scholarship/ Professional Development	… creating and translating knowledge; pursuing and promoting scholarly activity; encouraging academic goals and academic advancement.
Accessibility	… being available in a timely, open, friendly manner; easily available physically and emotionally to our patients and colleagues; and offering timely access to necessary care, with support for those waiting

Research Strategy

Driving research excellence

The Context:

During focus groups informing the Department's planning process, some members expressed serious concerns about the future of research here. Support for a Clinician Researcher and for the Clinical Scholar program had been lost, the latter of which was to have been a vehicle for getting junior investigator awards. Attracting academic physicians is frustrated by our inability to protect academic time at least partly because recruitment is to and by the Divisions, and therefore biased toward clinical demands. And it's very hard to get funds for research supports.

Into the future, we must develop a research engine that drives more, high-quality, high-impact research. Evidence and critical thinking must permeate everything we do. The Department must attract academic thinkers and help them flourish … people who think of research as a career. Our islands of world-renowned outcomes researchers should expand into broader groups with more people involved, and all should be better recognized locally. Effective assessment of research productivity would be individual and not designed to highlight disparities across Divisions.

Recruitment preparation should identify specific gaps for which we're seeking interests and training. The Department might recruit into a number of key positions for the purposes of enhancing research productivity in areas of strategic focus. And we need to restore research support programming that all Divisions on all campuses can tap into. Stronger support also means proper mentorship and finding ways to compensate for lost earnings opportunities.

Goals& Implementation Initiatives

1.1 Grow a Culture of Scientific Inquiry	*To grow a culture of scientific inquiry by generating excitement around research excellence such that all Department members are involved in or supportive of research*	• **Integrate research** such that there is always a research question around the clinical work we do. • **Link to the Department's Communication Strategy** to heighten awareness and establish a profile for research. • **Expect leadership** from the Department Head and Division Heads as they demonstrate strong support for multi-disciplinary and multi-departmental research. Leverage active Division Head and Research Committee management in support of member research productivity. • **Recruit** to address research needs and reflect the Department's research goals. • **Provide a systematic orientation** to the Department's scientific culture that introduces current and new faculty to its research priorities, strategies, funding options, and available supports. • **Build a supportive research environment** that increases the odds of retaining talented faculty. • **Enhance mentorship,** formalizing it along the career continuum (including Residents). Set clear and specific expectations against which the quality of mentorship can be assessed. Design mentoring experiences so as to help people progress along the continuum of productivity. (See the next bullet.)

Research Goals & Implementation Initiatives (cont'd)

1.1 Grow a Culture of Scientific Inquiry (cont'd)		**Ensure that what we mean by productivity is clear.** Create a continuum that sets out expectations of deliverables associated with research time invested. Develop benchmarks for research productivity in relation to time protected and for clinical FTEs (to control impingement on research time).Support new 'research' faculty to become productive: Stipulate deliverables and a minimum proportion of total time to be spent doing research within an envelope of total academic time not less than 20%. • **Maximize all available funding opportunities**. • **Create a DoM Funding Strategy** for (a) doubling the capital within the UMIRF; and (b)funding for pilot data to help access larger funds; running a defined grant competition for multi-disciplinary collaboration.
1.2 Establish Research Priorities	*To identify and develop a research focus that complements the Department's clinical care and education activities*	• **Set research goals** that: (a) complement the Department's clinical care and education goals; and (b) focus on early identification and prevention of chronicity. • **Recruit and fund a critical mass of researchers** to achieve DoM research goals. • **Enhance research productivity** so as to be recognized as go-to experts in the field from a regional, national and international perspective.

Expected Outcomes

- ✓ Support for research as an asset relative to attracting talent and resources, not a liability.
- ✓ Via pre and post analysis, a Departmental ability to constructively influence the following outcomes:
  - The number of Department members with more protected research time;
  - The number of Department members actively involved with research;
  - Resident and Faculty research presentations and peer-reviewed publications nationally or internationally;
  - The number of Department members with peer-reviewed funding, fellowships and research chairs;
  - Reputation nationally and internationally.
- ✓ Synergies across the Department's clinical care, education and research mandates.
- ✓ Alignment with Department of Health & Wellness, CDHA, and Faculty of Medicine strategic priorities to address key system problems.

Education Strategy

Attracting and growing the best

The Context:

The Department of Medicine has long been a leader in medical education and our traditional model has worked quite well. However many reports, study groups, and experts are pushing for change in how medicine is taught and postgraduate students are trained[1].

As the medical education paradigm shifts, our Department must play a more sophisticated leadership role. Education itself is becoming much more evidence-based. Simulation will not be just a surgical technology but will have much wider appeal for instance in cognitive fields. To compete with centres that have faculty with PhDs in Education, we need people capable of, motivated by and tasked with educational scholarship. Some will choose clinician educator career paths. To remain a leader, we must bring innovation to the forefront of education.

Goals & Implementation Initiatives

2.1 Culture of Excellence & Innovation in Education	*To continue to build a culture where clinician teachers are encouraged, evaluated, and acknowledged for excellence and innovation in education*	• **Develop focused leadership** to champion and evaluate innovation in education. • **Support and provide opportunities** for DoM members to enhance their education skills and knowledge to be the best teachers possible. • **Use innovation to close gaps** between current resources and identified needs. • **Develop a mentorship program** and identify a network of excellent educators. • **Recognize DoM member excellence** in educational skills.
2.2 Educational Initiatives across the Continuum	*To promote and lead educational initiatives across the continuum of medical education*	• **Ensure effective integration and transitions** between each stage of the medical education process (e.g. Clerkship to PGY 1, PGY 1 to PGY 2). • **Help optimize clinical outcomes (**e.g. appropriateness of care) through inter-disciplinary education and Continuous Professional Development (including CME). • **Implement effective assessment systems**.
2.3 Best Internal Medicine Experience	*To create the best internal medicine experience in Canada*	• **Provide excellent training** for undergraduate and postgraduate trainees.

[1] For example, *The Future of Medical Education in Canada, A Collective Vision for Postgraduate Medical Education in Canada*. (2012) http://www.afmc.ca/future-of-medical-education-in-canada/postgraduate-project/pdf/FMEC_PG_Final-Report_EN.pdf

Expected Outcomes

Re: Learners

- ✓ Excellent evaluations of DoM members' teaching performance (from undergrad, post grad and practicing MD learners)
- ✓ Excellent results achieved on:
  - o Undergrad OSCEs in Internal Medicine;
  - o The Internal Medicine component of the LMCC
  - o Royal College Internal Medicine exams
- ✓ Top Dalhousie students choosing IM as a career
- ✓ Increase in the number of applicants to the Dal IM residency from across Canada and from Dal
- ✓ More Dal IM Residents:
  - o Obtaining top level fellowship positions;
  - o Becoming high-performing Faculty members at Dal and elsewhere;
  - o Highly sought after as academic leaders throughout the medical community; and
  - o Doing Masters in Clinical Investigation programs.
- ✓ Excellent Dal IM Residents returning after fellowships
- ✓ More Dal Residents who leave here/come here for research fellowships vs. clinical fellowships
- ✓ Expanded ability to offer funded and well mentored additional clinical and research training at the end of residencies:

Re: Faculty

- ✓ Recognition as leaders in medical education in the Maritimes
- ✓ More Dalhousie DoM Faculty positions sought after
- ✓ More DoM members:
  - o With formal educational training;
  - o With improved educational skills;
  - o Who become clinician educators (and their impact);
  - o Representing the Department at Faculty and CDHA decision-making tables
- ✓ An increase in the number and mix of DoM members involved in external education leadership roles (e.g. Royal College Examiner)

The Context:

With chronic needs more complex than any one discipline can address, many patients often find themselves shuffled back and forth between community or continuing care settings and acute interventional settings. Once in the acute setting, they can be seen by a number of professionals across disciplines. Our traditional models result in less than optimal experiences and outcomes for two types of patients: (a) people who are living longer with multiple, complex chronic conditions; and (b) people whose care becomes more complex and costly than necessary.

Our fragmented, traditional model focuses sub-specialty expertise on individual diseases; no one sub-specialist has the complete picture for a patient with multiple morbidities. Diagnostic and service volumes are generated from these disaggregated perspectives without regard to appropriateness, consistency, value, or impact on the sustainability of the system as a whole. Follow-up is not integrated and we lack unified accountability for desired patient outcomes.

Getting this right for these patients is not only good care, but also imperative for the system itself. Rather than continuing to view these patients in isolation, we will change our direction and embrace the challenge of altering how their journeys unfold. Indeed a number of Divisions and other Departments are leading initiatives to address these issues within their parts of the continuum (e.g. PATH, Inspired, Care by Design). We will build on these and establish better links to Family Medicine and Continuing Care. Practice variations will be minimized as we cultivate new definitions of appropriateness based on standards of care and the patients' goals. Better coordination through proactive development of new models can improve the patient experience and address quality and sustainability issues.

Goals & Implementation Initiatives

3.1 Frail patients with multi-morbidity	*To improve health care of frail patients with multi-morbidity and enhance their experience of required complex care while reducing or at least controlling per capita costs.*	**Strengthen Assessment & Care Planning across the Continuum, through:** • Comprehensive Intake Assessment • Enhanced Care Plans: formulation, communication/ coordination and implementation • Facilitated Advance Care Planning that moves across settings and includes goals of care assessment and documentation **Improve Access to Appropriate Care through:** • Home visits: (i) scheduled and involving NP/Advance Practice RNs with robust support from the District Department of Family Medicine & Department of Medicine physicians working as a coordinated team; and (ii) unscheduled and involving NP/Advance Practice RNs or physicians for changes in status requiring semi-urgent assessment with emphasis on home-based assessment and treatment whenever feasible. • After-hours care in the home	Note: We will focus first on those who are *already* frail with multi-morbidity. If we become more effective at managing the condition of those patients, Divisions will have more time and resources to work with Geriatrics and Primary Care on prevention.

Clinical Care Goals & Implementation Initiatives (cont'd)

3.1 Frail patients with multi-morbidity (cont'd)	*To improve health care of frail patients with multi-morbidity and enhance their experience of required complex care while reducing or at least controlling per capita costs.*	**Improve Access to Appropriate Care** (cont'd) • Integrate access to care in the community … i.e. Continuing Care, VON services, community-based allied health professionals and outreach teams. • Streamline access to hospital (e.g. Community Health Unit), bypassing the ER for those needing admission. • Streamline access to home-based and community specialist services: e.g. via outreach teams and optimal use of telemedicine. • Use EHS Special Population status for crisis intervention/adherence to documented goals & advance care plan. **Enhance Team Functioning & Supports** • Clarify roles and enhance coordination among providers. Introduce a Clinical Case Manager role. • Conduct weekly team rounds to address patients whose status is changing. • Achieve real-time quality improvement with prospective outcome data collection. • Enhance collaboration and coordination to support primary care.

Expected Outcomes: Frail Patients with Multi-Morbidity

- ✓ Reduced fragmentation and inefficiency through better coordination and a more patient-centred approach. We help reshape the system into a continuum that reflects patient needs, largely by reallocating/consolidating existing resources.
- ✓ More appropriate care by strengthening integrated, multi-departmental team-based models for patients: (i) with advanced COPD, CHF, Dementia, end stage liver, renal or neurological disease; (ii) with frailty defined by established inclusion criteria for advanced illness; (iii) living in a pilot geographic area; and (iv) homebound and dependent for >1 activity of daily living.
- ✓ Via pre and post analysis, a Departmental ability to influence:
  - Health Care Utilization (hospitalizations, ER visits, % days home vs. hospital, diagnostics) and related costs
  - Clinical Outcome Measures and Symptom Scores
  - Patient/Family Satisfaction
  - Family Physician Satisfaction
  - Family Caregiver Burden
  - Prevalence of/adherence to an Advance Care Plan
- ✓ Alignment with Department of Health & Wellness, CDHA, and Faculty of Medicine strategic priorities to address key system problems.

Clinical Care Goals & Implementation Initiatives (cont'd)

3.2	**Appropriate Levels of Care**	*To appropriately triage patients to tertiary, secondary and primary levels of care*	**Improve Access to Appropriate Care** • Have <u>each</u> Division identify target populations. • Develop cost-effective methods for guiding these patients through the system, with the most appropriate access to primary, specialist and subspecialist care and services. • Provide education and support for specialists in spotting and helping inappropriately referred patients get care appropriate to their situation. • Other, TBA **Enhance Team Functioning & Supports** • Provide education that helps primary care providers spot and appropriately treat/support these patients. • Provide education and support for primary care providers in making the most appropriate referrals. • Other, TBA

Expected Outcomes: Appropriate Levels of Care

- ✓ Reduced fragmentation and inefficiency through better coordination and a more patient-centred approach. We will achieve this largely by reallocating/consolidating existing resources.
- ✓ Optimized overall system capacity, by ensuring the appropriate use of care and supports for patients with medically unexplained symptoms or with symptoms more appropriately addressed at the primary care level.
- ✓ Lower costs due to the inappropriate use of expensive diagnostics
- ✓ Alignment with Capital Health's strategy for maximizing the appropriate use of ambulatory settings.
- ✓ Enhanced collaboration and communication with Family Physicians
- ✓ Improved quality of care
- ✓ Improved access / reduced wait times