# Family Practice Quality and Capacity Study

## A research study into the issues affecting Family Practice in the Capital Health Region

## Initial Report to the Family Practice Quality and Capacity Steering Committee

**April 25, 2001**

*Department of Family Medicine*

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# Introduction

*The purpose of FPQC*

The purpose of the Family Practice Quality and Capacity (FPQC) Study is to determine family physicians' perspectives on the quality and capacity of family practice services in the Capital Health Authority (CHA) and to develop strategies in order to enhance quality and capacity.

The initial phases of the FPQC Study have been conducted by the Principal Investigator, the Project Manager and the Project Consultant. These phases related specifically to the thesis of the Principal Investigator and were conducted independent of a project Steering Committee.

A Steering Committee is now being established to guide the FPQC Study through its final phases. The purpose of this paper is to provide the Steering Committee with the findings of the study to date.

# Background

*History of FPQC*

The FPQC Study is being conducted by the Department of Family Medicine, through a grant from the Alberta Medical Association (Medical Services Budget Innovation Fund). Dr. David Moores is the Principal Investigator.

A proposal was developed in early 2000 in response to a call for submissions to the AMA MSB Innovation Fund. A number of individuals provided letters of support for the proposal, including 20 family physicians from family medicine teaching practices in Alberta.

The overall project was designed to be conducted in three phases:

Phase 1 – Identification of Issues: The Family Practice Quality and Capacity Study
Phase 2 – Interventions: Family Practice-Initiated Intervention Study
Phase 3 – Outcome Measures: The Family Practice Quality, Capacity, Comprehensiveness and Sustainability Project.

The current funding is for phase 1 of the project. Additional funding will be sought for the subsequent phases.

*The need for FPQC*

The provision of high quality family practice services is critical to the health care system in Alberta, yet what constitutes quality family practice and the capacity to provide services in the system are not

known. Currently there is marked variability between family physicians regarding the scope of services provided, after hours call and availability, and the degree to which they provide in-hospital care. Identifying the opportunities and barriers to improved quality and increased capacity in family practice has the potential of advancing best practices in primary care/family practice. The input of family physicians concerning issues of capacity and quality of health service delivery are fundamental for primary care reform.

The basic concept behind the project is to provide a systemic approach to assessing quality and capacity issues in family practice in order to develop strategies for recommendation and potential implementation.

*Shortage of Family Physicians*

The rationale for FPQC comes from a recognition that there is a crisis in the health care system in terms of availability, or perceived shortages, of family physicians for the provision of certain services. At the same time, a number of changes are being made to the health system in order to enhance primary health care, sometimes with little involvement from family physicians themselves.

In the Capital Health Authority, there are over 800 physicians listed as family physicians/general practitioners[1]. However, less than 600 of these are actively engaged in family practice within the region, and some of these less than full time.

The Association of Canadian Medical Colleges (ACMC) has identified a significant shortfall in the numbers of graduates from medical school in the next five years. The Alberta government has accepted this reality and has increased both the number of positions in medical schools and in residency training as of this coming year.

In 1997/98 the College of Family Physicians of Canada (CFPC) conducted a national study of family physicians. In the Alberta Report[2], 65% of the responding physicians indicated that there was an accessibility problem in their community. 45% indicated this was due to a shortage of family physicians.

The shortage of family physicians may impact on the ability of family physicians to provide adequate and appropriate services to patients, but there are other issues as well. The FPQC Study is in the process of identifying these other issues in relation to quality and capacity of family practice in the CHA.

[1] College of Physicians & Surgeons of Alberta, 2000 database provided to FPQC Project Team in March 2001.
[2] The CFPC National Family Physician Survey; Regional Report – Alberta: www.cfpc.ca/Janus/janusregab.htm

*What is quality?*

In terms of family practice, quality includes a physicians' ability to provide excellence in care. The goal of excellence should be manifested in all four of the principles of family medicine, namely clinical care, effective doctor/patient relationships, being a resource to practice, and being community based.

*What is capacity?*

Capacity includes the ability of a physician to meet the multiple, and often competing, demands of patients, the profession, the health system and personal life while maintaining appropriate standards of care.

## Role of the FPQC Steering Committee

*The need for a Steering Committee*

The initial activities of the FPQC Study were overseen by a small Project Management Team. The FPQC Study is now entering into a stage where a larger number of people, and organizations, need to become involved. An FPQC Steering Committee is currently being established.

The FPQC Steering Committee will advise in the development of a questionnaire to assess the representativeness of focus group issues. The Steering Committee will also identify and prioritize potential projects. Members will then identify project sponsors or champions and begin developing project proposals for funding and implementation.

All potential projects identified by the Steering Committee will be linked back to the themes and key learnings identified in the focus groups and questionnaire.

A draft Terms of Reference for the Steering Committee is included in Appendix 1.

## Contextual Information

*What's happening?*

Definitions of primary health care vary, as do approaches to enhance delivery. One definition used in Alberta is – "Primary health care is the first level of care, and usually the first point of contact, that people have with the health system.[3]"

Family physicians play an essential role in the delivery of these services. However initiatives are frequently undertaken without a thorough discussion with local family physicians to identify issues, challenges, and willingness to participate. The FPQC is identifying

[3] Alberta Health & Wellness 2001 – Health Transition Fund documentation.

issues from the perspective of the family physicians and developing potential strategies to address these issues. By involving the family physicians from the beginning, and developing strategies to address their issues in relation to quality and capacity, the delivery of primary health care in the Capital Health Authority will be strengthened.

Jurisdictions across Canada (including Alberta) are examining the health system and testing innovations to enhance service delivery, frequently focusing on primary health care or primary medical care delivery. Before embarking on new initiatives within Alberta it is important to examine what activities are already underway.

## Alberta

*In Alberta*

### Health Transition Fund (HTF)

Alberta Health and Wellness, with dollars from the federal Health Transition Fund (HTF), funded 27 diverse primary health care projects under the umbrella Alberta Primary Health Care Project, mostly involving regional health authorities. The projects were implemented from approximately September 1998 to May 30 2000, with a final evaluation report for the umbrella project being submitted to the HTF in September 2000. The types of primary health care projects funded include:

- evaluation of existing activities/models/approaches;
- enhancement and evaluation of existing activities/ models/ approaches; and
- implementation and evaluation of new demonstration projects.

A listing of the HTF projects can be found in Appendix 2.

### Health Innovation Fund (HIF)

The Health Innovation Fund (HIF) was announced by the provincial government in March 1999. The purpose of HIF is to promote and facilitate health system reform as well as encourage more effective health service delivery within the province.

In March 2000, Health & Wellness announced funding for 33 projects through the Health Innovation Fund (HIF). These 33 projects were approved based on their ability to:

- Improve the quality and/or efficiency of health services
- Demonstrate innovative approaches to delivery or introduce a new health service to a different setting
- Increase capacity for sustainability

- Demonstrate/encourage partnership/collaboration in support of regional and/or provincial business plans
- Be independently evaluated

In March 2001 an additional 15 projects were approved for funding.

A complete listing of HIF projects can be found in Appendix 2.

**AMA Medical Services Budget Innovation Fund (MSBIF)**

The MSBIF was part of the previous agreement between Alberta Health and Wellness (AHW) and the Alberta Medical Association (AMA) and provided one time support for innovative projects that enhance the delivery of insured services or improve patient access to needed physician services.

The MSB Innovation Fund was designed to encourage physicians and their partners to deliver or enhance the provision of insured services and/or to enhance patient access to needed care. Physicians were encouraged to collaborate with health partners, such as regional or provincial health authorities in developing their projects. In May 2000 the AMA and AHW announced approval for 20 projects funded for $3.8 million. In August of 2000, an additional seven projects received funding through the MSBIF, including the FPQC Study.

A complete listing of MSBIF projects can be found in Appendix 2.

**Alternate Payment Projects (APP)**

Alberta Health and Wellness and the Alberta Medical Association are interested in encouraging innovative, effective and flexible approaches to medical care delivery. To this end, they are working together to explore the development of alternative payments projects (APP) with interested physicians. This project is in keeping with the last AHW/AMA agreement and is a continuation of the work begun under the Tripartite alternative funding initiative in 1996.

An Alternate Payment Plan Subcommittee was established to oversee the development of alternative payment plans. Their purpose is to manage all APP matters relating to the AHW/AMA agreement, including development APP funding models and criteria, evaluating APP proposals and facilitating their development. To date, there are five APPs being piloted by Alberta physicians.

A complete listing of APPs can be found in Appendix 2.

### Consortium for Action Research in Primary Care

The University of Alberta, Department of Public Health Sciences, is leading the drive to establish a virtual, province-wide consortium of interested individuals and organizations to enhance research and policy development in primary care. The purpose of the Consortium is to: I) increase action research capacity; ii) increase knowledge of who is doing what/where in terms of primary care; iii) bridge traditional rivalries that fragment potential team efforts; iv) undertake policy analysis to help overcome ad hoc policy development; and v) create economies of scale.

## Major Initiatives in Other Provinces

*In other jurisdictions*

Some of the key primary health care initiatives across Canada include:

### British Columbia

Primary Care Demonstration Project – a joint research project between Health Canada and the BC Ministry of Health designed to explore innovative approaches for the delivery of health care services. This project is funded through the Health Transition Fund. More detailed information is available at –
http://www.hlth.gov.bc.ca/care/primdemo/index.html

### Saskatchewan

The Saskatchewan Ministry of Health has established a branch to promote the introduction of team-based service delivery for basic health services and to support, and facilitate, the development of primary health service demonstration sites. At this time there are 18 Primary Health Service Sites in operation or under development. More information can be found at –
http://www.health.gov.sk.ca/ps_phs_services_over.html

In June 2000, the Saskatchewan government appointed a Commission on Medicare, chaired by Kenneth Fyke. This Commission has recently released its findings and provided recommendations that may impact the delivery of primary health services in that province (*Caring for Medicare: Sustaining a Quality System*, April 2001). More information can be found at - http://www.medicare-commission.com/reports.htm.

## Ontario

In March 2000 the Ontario Health services Restructuring Commission (HSRC) released its report *Looking back, looking forward - Seven Points for Action* (http://www.hsrc.gov.on.ca/). HSRC was an independent body established in 1996 to expedite hospital restructuring in Ontario and to advise on the revamping of other aspects of health services system in the province. The work of HSRC has influenced the direction of primary care initiatives in Ontario.

Through the Health Transition Fund, Ontario has implemented a number of projects, most notably the Primary Care Reform Implementation and Evaluation (http://www.hc-sc.gc.ca/htf-fass/english/provincial_e.htm). This project involves the development and evaluation of a new model of health services delivery in communities across Ontario. This new model is offered by physicians and involves different ways of organizing, funding and delivering primary care.

In March 2001, the Ontario government announced the creation of Family Health Networks. These Networks will be led by doctors, working with nurses and other health-care professionals, to provide access to care or advice, 24 hours a day, seven days a week. A new agency, the Ontario Family Health Network chaired by Dr. Ruth Wilson, has been created to oversee the addition of many new, voluntary networks across the province. The Ontario government is investing $250 million in family doctor services to support Family Health Networks, with a target to see 80 per cent of family doctors join a network. The government and the OMA have already established 12 Family Health Networks in five communities. Joining a network is voluntary for both doctors and patients. More information is available from - http://www.premier.gov.on.ca/english/news/Health032101.htm.

The Ontario College of Family Physicians has been very active in researching and discussing issues in primary health care reform. In April 2000, the College released its discussion paper, *Family Medicine in the 21st Century – Implementation Strategies*. Since then they have developed and released three follow-up papers on implementation strategies – *Collaboration in Primary Care – Family Doctors & Nurse Practitioners Delivering Shared Care* (May 2000), *Protecting trust in the Patient-Physician Relationship* (June 2000) and *Too Many Hours, Too Much Stress, Too Little Respect* (July 2000)[4].

[4] Ontario College of Family Physicians, all four papers 2000; http://www.cfpc.ca/ocfp/commun/publitns.html

### Nova Scotia

Through funding from the Health Transition Fund, Nova Scotia Department of Health is implementing a series of primary care demonstration projects , in order to support primary care providers and communities who want to try new ways of delivering primary care services by building on the strengths, innovations and leadership that exist within those communities. More information is available through - http://www.gov.ns.ca/health/.

## National Initiatives

*At the national level*

In October of 2000 the College of Family Physicians of Canada (CFPC) released its discussion paper *Primary Care and Family Medicine in Canada – A Prescription for Renewal*[5]. In this paper the CFPC presents a model for the delivery of primary care services by family doctors, nurses, and other health care providers. It offers strategies and recommendations for creating and sustaining this model.

Through its National Family Physician Survey (NFPS), the CFPC has established the first, and only, national level source of information to provide in-depth information on the role of family physicians in Canada – referred to as the Janus Project – launched in 1996[6]. The NFPS is an on-going data collection initiative and offers up-to-date, dynamic information about family doctors. The 1997/98 survey focused on measures of family physician workload, clinical settings, range of medical services offered and types of communities served. In February 2001, the CFPC sent a questionnaire to all family physicians in Canada. The 2001 survey focuses on about the extent to which physicians have closed their practices, their ability to access extended healthcare services and their role as coordinators of the healthcare services their patients receive.

[5] *Primary Care and Family Medicine in Canada – A Prescription for Renewal,* College of Family Physicians of Canada ;October 2000; http://www.cfpc.ca/prescription-oct00.htm
[6] College of Family Physicians of Canada – Janus Project: http://www.cfpc.ca/Janus/janushome.htm

# Methodology

## Overview

*How is the FPQC study being conducted?*

The FPQC study is being conducted in four phases:

1. focus groups with selected family physicians – to identify the issues relating to quality and capacity within the CHA
2. identification of major themes from the focus groups
3. questionnaire development based on major themes - to be sent to family physicians within the CHA
4. development of strategies to enhance quality and capacity of family physicians within CHA – based on the results of the questionnaire.

## Focus Groups

*Who participated in the focus groups?*

Two series of focus groups were held with family physicians in the Capital Health Authority. Series 1 included seven exploratory focus groups that took place between November 14 and December 11, 2000. The Series 2 focus groups consisted of two follow-up sessions to validate the major impressions from the first series and to further explore the major themes. These occurred December 12-13, 2000.

Series 1

The Project Management Team initially identified a group of 15 family physician practices which where known to provide a relatively comprehensive range of family practice within the Capital Health Authority. These practices had previously been identified as teaching practices through the Department of Family Medicine, although not all of the physicians within a practice were affiliated with teaching. All of the practices consisted of community-based family physicians. No full-time academic physicians were included in the selection process.

After the first two focus groups, the researchers questioned whether the responses would be different from physicians in other types of practices, ie. non-teaching, higher volume or 'walk-in' clinics. A decision was made to hold an additional focus group in the initial series for physicians from higher volume, walk-in clinics.

| Physicians invited to participate | Physicians agreeing to participate | Physicians attending a focus group |
|---|---|---|
| 95 | 51 (53.7%) | 46 (48.4%) |

## Series 2

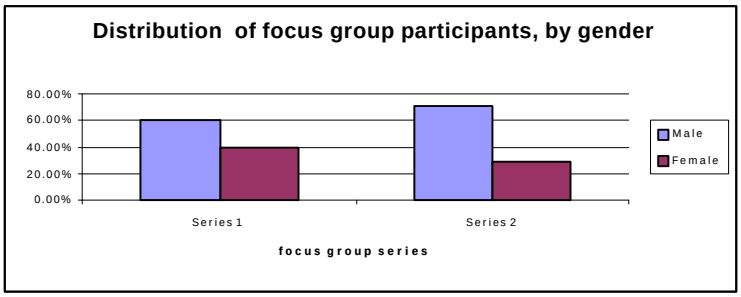
Although the analysis of the focus group data was not complete, the researchers were able to identify some very broad reccurring themes from the focus groups. They felt that it would be useful to bring back some of the Series 1 physicians and present them with the themes and generate additional discussion around the themes. Twenty-one of the 46 physicians from Series 1 were invited to participate in one of the Series 2 focus groups.

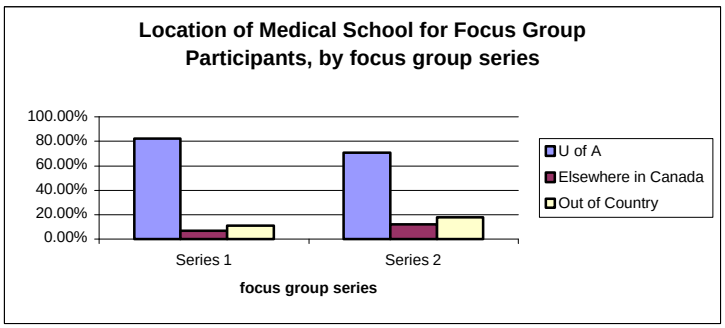
| Physicians invited to participate | Physicians agreeing to participate | Physicians attending a focus group |
|---|---|---|
| 21 | 17 (81%) | 17 (81%) |

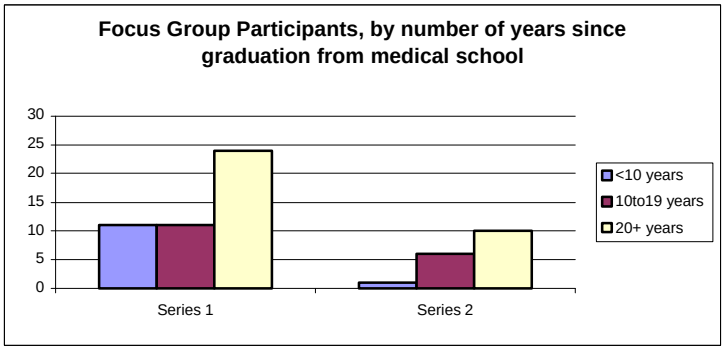
## Demographic Information on Focus Group Participants

The following charts show the gender distribution, location of medical school and number of years since graduation from medical school for focus group participants.

*What are the characteristics of the focus group participants?*






Focus Group Data

Dr. David Moores, Principal Investigator, facilitated the focus groups. Two observers were present at the focus groups. Each focus group was audio-taped and these tapes were then transcribed for analysis.

The transcripts were analysed to determine the major themes arising from the focus groups. The Principal Investigator had primary responsibility for the analysis, with assistance from the Project Manager and the Project Consultant.

## Questionnaire

*A questionnaire to gauge responsiveness of doctors to potential scenarios developed to address quality and capacity issues.*

A questionnaire is currently under development to be sent to all physicians providing family practice services within the CHA. The purpose of the questionnaire is to – i) determine the representativeness of the focus group themes and issues, ii) identify new issues, and iii) gauge responsiveness of family physicians to potential scenarios developed to address quality and capacity issues.

Data was obtained from the College of Physicians and Surgeons of Alberta (CPSA) on family physicians/general practitioners registered with the CPSA as of the end of 2000.

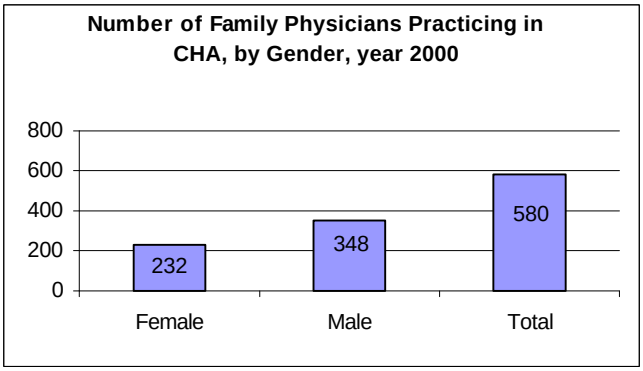
The database contained information on 821 physicians with an address within the CHA boundaries (up to three addresses per physician can be on file – primary practice address, secondary practice address and home address). Of these, 13 physicians were removed because they had not filled out the questionnaire indicating that they practice within CHA; 29 were removed because they indicated that they don't practice at all within CHA; an additional nine physicians were removed because they practice in CHA less than 50% of their time; leaving a subtotal of 770 family physicians/gps practicing within CHA.

The data on the remaining physicians was examined to determine how many physicians indicated that they practice other than family medicine. A total of 190 physicians were removed because they don't practice 'general practice' according to their own categorization. Anyone with less than 50% general practice was removed.

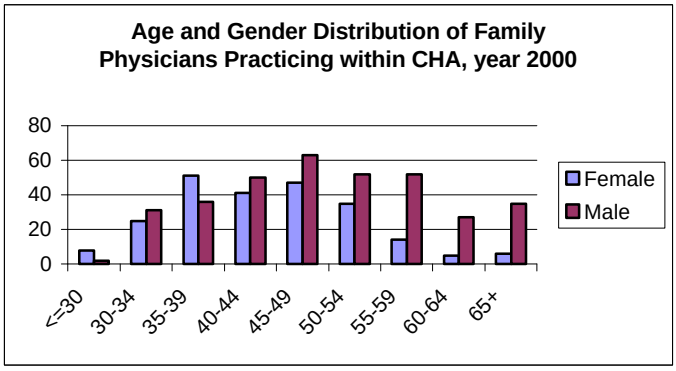
*Who are the family physicians in CHA?*

This leaves a total of 580 physicians delivering general practice services within the CHA.

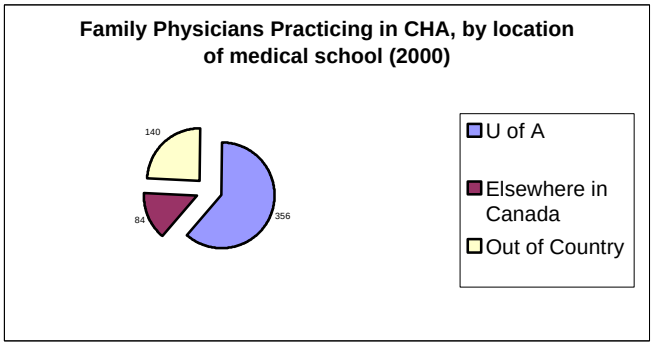
The following chart shows the gender distribution of the physicians.

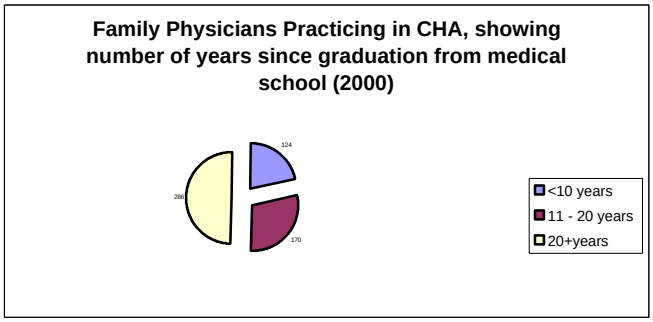



The next chart shows the age distribution, by gender, of physicians practicing family medicine within CHA.




Family physicians by location of medical school and by number of years since graduation from medical school are shown in the following two tables.


Family Physicians Practicing in CHA, by location of medical school (2000)
140
84
356
U of A
Elsewhere in Canada
Out of Country


Family Physicians Practicing in CHA, showing number of years since graduation from medical school (2000)
124
286
170
<10 years
11 - 20 years
20+years

# Themes

## Time

*"Time" is the number one issue with family physicians*

Time is identified as the number one issue related to both quality and capacity.

Participants consistently remind the research team and themselves of the tremendous strain on family physicians in the provision of quality comprehensive health services. Much of the reflection of participants is focused on the activities involved in trying to meet personal and professional induced targets of quality. In particular the energies induced to accessing diagnostic and treatment services are enormous. The subsequent time involved in tracking, following and trying to make a dysfunctional system work is reflected in phrases like: "It would make you weep", "I am very frustrated", "I am a fool to be doing this".

*"The biggest issue I have when it comes to quality and wanting to maintain quality… is time. I no longer have the time to do what I need to do and to do what I was trained to do to be a good family doctor."*

Several participants highlight their perception that there are many activities in which they engage that could or should be done by another health professional or another individual. This is in addition to those activities that are seen to be complete "time wasters".

A facet of time is the increasing complexity of patients in family practice and the increasing activities required of family physicians in health promotion, health maintenance and illness prevention.

Another facet of time relates to the continuing professional demands of professional development. Although continuing medical education is cited several times, the unique demands on family physicians in terms of breadth and depth of knowledge and skill maintenance and development concerns both younger and more experienced physicians.

There is a clear commitment to spending the "appropriate amount of time with the people who need it". Many family physicians express a wish to cut back on the numbers of individuals seen in any one clinical session in order to do a better job and enhance the impact of a therapeutic and effective relationship on the health outcome of an individual patient.

Family physicians have suggestions as to how to create and maximize the time available for their professional activities. Consistently we hear expressions of concern about the total responsibility for time efficiency and services depending on the willingness and ability of family physicians to fund or subsidize such initiatives. There is the perception that no investment in primary care is being made in primary care by the regional health authority and the issues of access to diagnostic and treatment services from a primary care perspectives continues to be ignored.

What are the time intensive, time demanding activities of these family physicians? Time with individual patients, trying to get the system to respond to the legitimate needs of individuals in addition to personal and family time are the most commonly cited examples.

Time accessing information both within their practice settings and from the acute care (hospital) and continuing care (home/palliative) is a concern. This coupled with the time involved in arranging access to testing, consultation, emergency room and hospital access has dampened the spirit, resolve and enthusiasm and energy of family physicians within the Capital Health Authority Region.

Throughout the remainder of this summary the themes identified should be viewed in the context of the overwhelming concern about the importance of time in addressing the quality and capacity issues and concerns of family physicians.

## Scope and Definition of Practice

*"One of the things that bothers me about quality is the way the system is designed… the driver being the episode of care. The family physicians who are surviving and thriving in fact*

Many family physicians express concerns about the roles and scopes of practice of both family physicians and specialists. The numbers and availability of family physicians providing a "comprehensive range of services" to a defined population is difficult to determine. The structure and organization of family practice services, the infrastructure, solo versus group practices, numbers and skill levels of support staff, all impact on the scope and definition of practice.

The perception of some family physicians is that there are family physicians that provide very limited or restricted services to the detriment of the public at large in addition to the detriment of family physician colleagues. This limited service provision may be a survival strategy for individuals to cope with the impossible demands placed on or assumed by family physicians.

*are the ones that are happy to just scratch the surface or just touch the surface. Skip over the problem and forget about all those issues and just deal with that little episode of care. Forget the fact that the patient has diabetes or hypertension or needs a Pap test or needs a mammogram or needs to stop smoking."*

Family physicians offering comprehensive services (home visits, hospital care, palliative care, obstetrics etc.) express concern about those individuals who don't.

The activities of some specialists and specialist programs in providing primary care services is cited as compromising access to specialty services and consultations (e.g. lung transplant, cancer care, cross referrals in the hospital sector). Patients who access specialty programs are subsequently encouraged to seek primary care services through that program, rather than returning to their family physician. Consequently, availability of consultative time is reduced.

Personal and professional expectations leave many practitioners with concerns about their ability to deliver services. In addition physicians feel that health bureaucrats, medico-political bodies and others make unrealistic assumptions and promises on their behalf. Assumptions about what family physicians can and will do vary from one extreme to another. The assumptions range from "they're not able, capable, competent or willing to do anything", to that of "they can do it all".

There are concerns about the declining trend in the provision of in-hospital care by family physicians. Working shifts in the emergency room, the provision of palliative, obstetrical and home care services are areas in which family physician clinical leaders express worries. Concerns are expressed about family physicians who just scratch the surface in terms of comprehensive care. Generalizations about the roles, impact, cost effectiveness and value of higher volume lower intensity physicians abound. Stereotypes of the process of common clinical scenarios e.g. the management and treatment of people with upper respiratory tract infections and the lack of comprehensive education in dealing with women newly diagnosed with a pregnancy form the basis of that discussion.

## Remuneration

*"Quality is something the system absolutely doesn't come even close to paying for. People looking after patients within our system are*

The relationships between remuneration and quality and capacity are significant in terms of the frequency of concern expressed by participants. The fee for service system and a fee schedule bearing no relationship to complexity or numbers of problems at any one visit concerns many family physicians.

It is clear there is a high level of interest in exploring those remunerative systems and schedules that better reward a focus on quality or comprehensive services. As a minimum, there should not be a penalty

*concerned about it but most of us are tired and burned out."*

for providing such services. There is a concern that the tools and infrastructure that would maximize quality and capacity are currently not funded through the fee-for-service payment system.

Many family physicians feel they do some of the things they do for free. They are driven by a professional and altruistic ethic to "do the right thing", often at significant costs to themselves and their families. There is a level of despondency, anger and resentment for not being recognized financially, attitudinally and organizationally for the fundamental services being offered and provided to the citizens of the region.

*"I open my drive through window at about 9:00 AM and I start serving. That's really what it comes down to. If you don't have a practice like that you run into trouble with your income. If you spend half an hour on a $22.60 pretty soon you're a pauper…because you spend more money than you're earning."*

Despite clear research evidence (Starfield and others) on the critical role of primary care in terms of equity and outcome, our family physicians feel undervalued, marginalized, under resourced and taken for granted! Family physicians are being asked to pay for, or subsidize the costs, of more effective quality practice. In that they are unique in the health care system. No other group of physicians is asked to pay for it themselves! When compared to those physicians working primarily within the structure of the acute care/hospital care system or those paid by salary or contract, family physicians and their patients are clearly disadvantaged. There is a high level of interest in funding mechanism alternatives and different levels of remuneration to enhance quality and adequately remunerate family physicians for good work.

## Access to External Resources

*"Why are there two tiers of medicine? If you're a specialist you've got one (tier), and if you're a GP you've got another one… I get tired of having to fight the system to try to get the facilities and treatment that my patients need."*

The resourcing of primary care/family practice by the regional health authority is seen as an important if not critical feature to the provision of comprehensive health services to the Capital Health Region. However the internal resources of family practices in the region are wholly funded and supported through the overhead expenditures of family physicians.

Rules, regulations and protocols, often developed with an acute care/institutional mind set, and presumptions about the quality, capacity and critical appraisal skills of primary care/family practice services appear to have relegated physicians to two classes-the privileged "haves" and the non-privileged "have-nots". Community based family physicians are the majority of this non-privileged group.

In a health care environment perceived by family physicians as under-resourced and under-funded some physicians are seen to have preferential access to diagnostic and treatment services. In particular hospital-based specialists and emergency room physicians are seen to be able to order and access tests and consultations and special service programs in a timely way with relatively timely results.

*"How about consultants? That's one of the things that compromises quality as well… You do all these letters and six weeks later you get a letter back from the specialist saying, "due to time constraints I won't be able to see your patient for a year, I would suggest you send them to someone else". So you've wasted six weeks or the patient wasted that six weeks."*

Family physicians, both in their offices and in the community are often faced with major difficulties in accessing such services. The inequity of resource access is particularly galling when family physicians witness what they perceive as the wasting of limited resources through duplication, fragmentation and poor communication on the part of the acute care sector.

Perhaps the single most voiced concern of participants is access to consultative services. The waiting time for consultations with many specialists has adverse consequences on patient and family health. The secondary effect on the family physicians' resources, caring for patients with increasing complications as they await specialist services is significant.

Currently there is no means of obtaining a five minute verbal consultation from specialist colleagues. A focused discussion between family physician and consultant is a valued option for many family physicians. At the same time family physicians are sensitive to and respectful of the demands placed on specialists. Concerns about the adequacy of work-up on the part of family physicians prior to the request for consultation are voiced.

Family physicians are not happy with their access to illness specific programs for people with diabetes, obesity, asthma, mental health problems and other illnesses in the community. Ideally they wish to provide such services in house without having to send people away. However, their inability to access such services, in a timely way, anywhere within the system, compromises quality and capacity.

## Communication

There are several communication links between family practices and other health care services that are ineffective and dysfunctional. These are detrimental to patients, costly to the system and frustrating to all.

*"I haven't seen this patient since I sent him to the orthopod to get surgery. Now I found out they have had surgery and I'm responsible for looking after them."*

Patients are denied access to essential information pertaining to hospitalization. Their family physicians are often unaware of the patient's admission, consultations, test results, treatment initiatives and discharge planning. The follow up care without adequate information becomes unsafe and frightening.

Emergency visits usually require patients to see family physicians within a short follow up interval. The emergency documentation is usually illegible and access to test or consultations reports are difficult or impossible to access in a timely fashion.

There is a negative impact on decision making, patient satisfaction and efficiency due to difficulty accessing reports from lab, diagnostic imaging or consultations. This is sometimes caused by issues with the providers of the services and other times this is compounded by lack of effective information systems within the family practice.

Patients who visit episodic care providers and then follow with their own family physician cannot access the episodic care provider's medical record. Patients deserve access to all medical records pertaining to their care in a timely fashion.

Family physicians need to access the medical care records and treatment plans from multidisciplinary teams providing care to their patients in community programs. Currently they are often unavailable.

As family physicians seek to collaborate with other primary care team members, effective communication is impeded by organizational structures that often reallocate team members and interrupt team building or continuity.

## Practice/System Infrastructure

*"The regions should be investing in family medicine because we are looking after their citizens in the community. We are doing our best to try to keep them out of*

The expectation of benefit from a system organized around primary care is a commonly held belief within our focus group participants. The benefits of continuing care, having a defined practice population and having a different system of remuneration is assumed by physicians even if they are not aware of the research evidence of that benefit. However the expectation that family physicians will fund teams on their own, at their own expense is not supported. There are hopes and expectations that the health authority's success in organization will be applied to primary care.

*hospital…where all of the funding is flowing. "*

The Capital Health Authority is seen to have a great deal of potential in bringing to primary care some of its strengths and successes that are evident in the hospital and institutional sector. However, when compared to the organizational aspects of the acute and continuing care structures within the CHA, primary care lacks this major strength of the hospital sector. The perception that secondary and tertiary specialist care is more important and therefore warrants public funding for infrastructure is understandable given the lack of investment in primary care.

*"When we have a complicated patient in the hospital there is no question we are working with that patient as a team. The patient in the office these days is often as complicated as that patient in the hospital… so really we should…it would be ideal to have access to those same resources."*

There is a general dismay at the fragmented and duplicated system within which family physicians practice. This fragmentation and duplication is not only relevant to the many primary care players in the system but also to individual citizens. The opportunity to work with a team is often cited as being important in addressing quality and capacity issues. However, the current prerequisite of self-funding, where team effectiveness in itself compromises the ongoing funding of the team, effectively quashes any possibility of the team being developed.

A distinction is made between the capacity and quality issues of solo family physicians versus family physicians working in a group. Consistently we heard about the importance of a group of physicians being large enough to "afford" equipment and other health professionals. There is a willingness to consider sharing such people between physician groups.

## Physician Resource Planning

*"Its maybe a lack of confidence. Students and residents don't get good exposure. They might be at the University, where they are told that we're really lower life forms and that we really don't know how to do very much."*

The perception that there are insufficient numbers of family physicians is widely held among focus group participants. The numbers of men and women going into medicine and into family practice are a concern, as is the number staying in the Edmonton region and Alberta.

The choice of family medicine as a career discipline appears impacted by many factors in addition to the issues of adequacy of remuneration and quality of professional life. Within the medical hierarchy the discounting of the importance and difficulty of family practice is regularly witnessed by medical students and postgraduate physicians. Why would people choose family practice as a career choice against this background?

The numbers of family physicians needed for the CHA region is a challenging question. Full time equivalency and its definition coupled with concerns about scope and limitations of practice are of general concern. The concept of full time equivalency, number of hours worked, out of hours call, scopes of clinical practice (range of services provided, solo or group practice, the presence or absence of a team, equipment and infrastructure support and lifestyle expectations are some of the variables that need to be considered.

The numbers of practices that are closed to new patients is a concern to family physicians. The capacity to take on more patients and more responsibility is almost non-existent. New practices have been saturated very quickly with very little room for additional patients.

In order to consider the numbers of family physicians necessary to provide services to the population, it is important to consider the roles, responsibilities and numbers of other resources in the health system. The circumstances surrounding the number of consultants, the support of their professional lives (OR time, equipment etc.) impact the support they can provide to family physicians and their patients. In addition, the roles of nurses, homecare nurses, palliative care nurses, nurse practitioners, pharmacists, psychologists, social workers, physiotherapists, health educators, nutritionist, dieticians and administrators must be taken into account.

## Accountabilities

*"I agree with the patient accountability, but I think that comes with physician accountability and team accountability."*

*"We have to have the ability to have leadership over medical care. We can't give that up. But that doesn't mean controlling the*

Focus group participants express concern about a wide range of accountability issues. Concerns about professional behaviours (scope, depth of practice, availability initially and for follow-up) and patient accountability (multiple doctoring, keeping appointments, following through with testing) are linked with both quality and capacity.

Many patients display behaviours that impact both the quality and the capacity of family physicians. Not keeping appointments (no-shows), failure to follow-up on tests, doctor shopping and the inappropriate utilization of services were some of the issues cited. Some patients demonstrate an apparent unwillingness to spend time and prepare for the interaction the way one might in seeing a lawyer or accountant. Rude, aggressive, abusive and inappropriate behaviours on the part of patients round out the list of concerns.

*team…controlling the patient. It's really different."*

Some specialists, who have an ongoing doctor/patient relationship for patients with chronic conditions, create problems by requiring formal consultation each time follow-up with patients.

Patients are vulnerable when the family physician does not accept responsibility for comprehensive monitoring of chronic disease and timely implementation of preventive care. This lack of focus on continuing care/continuing relationship on the part of some family physicians spawns the comment, "There are the GPs that are basically the quick fix".

When looking at teams, teamwork and leadership, there are concerns about delegation and liability. There are clear challenges to the commonly held perspective that the physician must always be the leader. There is a respect for variation in leadership depending on the issue and expertise at hand.

# APPENDIX 1 – Terms of Reference

## TERMS OF REFERENCE - DRAFT 2
## FAMILY PRACTICE QUALITY AND CAPACITY STUDY STEERING COMMITTEE

PURPOSE:

In order to guide the Family Practice Quality and Capacity (FPQC) Study through its initial phase and obtain funding for subsequent phases.

The Steering Committee will study research findings on the issues related to quality and capacity of family practice services within Capital Health Authority; set and review priorities for potential strategies to enhance quality and capacity; develop (or assist in the development) of proposals for implementing selected strategies; and oversee implementation and evaluation of selected initiatives. The Steering Committee will determine appropriate mechanisms for continuing funding of the additional phases of the FPQC Study

COMMITTEE APPOINTMENT & COMPOSITION:

10 members

Members will be representatives of: the Department of Family Medicine (University of Alberta), Capital Health Authority, Caritas, Alberta Health & Wellness, University of Alberta (Consortium for Action Research in Primary Care), and community-based family physicians.

The Chair and Vice-Chair shall be representatives of the Department of Family Medicine, University of Alberta.

Committee support will be provided by the FPQC Project Manager.

TERM:

Chair ongoing
Members – 3 year appointments

MEETINGS:

Quarterly, or more frequently as required.

QUORUM:

2/3 of membership

TASKS:

1. Review issues identified from data collected through a series of focus groups held with family physicians from the Capital Health Authority.

2. Advise on the development of a questionnaire to be sent to family physicians in the Capital Health Authority.

3. Develop and prioritize a list of potential strategies for enhancing quality and capacity amongst family physicians in the Capital Health Region.

4. Identify strategies to be further developed, identify project champions, and assist in project proposal development.

5. Guide the implementation and evaluation of funded strategies.

REPORTING:

The FPQC Study will submit a final report of the study to the Alberta Medical Association at the end of the initial funding period. After that, regular annual reporting will be made to through the Department of Family Medicine and other involved organizations, as appropriate.

# APPENDIX 2 – Overview of Related Activities

## Health Transition Fund

Alberta Health and Wellness, with dollars from the federal Health Transition Fund (HTF), funded 27 diverse primary health care projects under the umbrella Alberta Primary Health Care Project, mostly involving regional health authorities. The projects were implemented from approximately September 1998 to May 30 2000, with a final evaluation report for the umbrella project being submitted to the HTF in September 2000. The types of primary health care projects funded include:

- evaluation of existing activities/models/approaches;
- enhancement and evaluation of existing activities/models/approaches; and
- implementation and evaluation of some new demonstration projects.

The 27 projects were:

Project Title – in order of listing.

**1.** Evaluation of 8th and 8th Health Centre
**2.** Evaluation of the Airdrie Regional Community Health Centre
**3.** Brooks Cares Project
**4.** Enhance and Evaluate COPE (Community Outreach in Pediatrics/Psychiatry and Education Program)
**5.** Evaluation of Enhanced Services at CUPS Community Health Centre - Integrating the Services of the Nurse Practitioner in the Inner City
**6.** Primary Health Care Project for Elnora Area
**7.** Enhancing Primary Care of Palliative Cancer Patients
**8.** Evaluation of a Primary Health Care Clinic According to Primary Health Care Parameters of First Contact, Longitudinality, Comprehensiveness and Coordination (UCMC Sunridge Evaluation)
**9.** Health for All (Metis Settlements and Lakeland Regional Health Authority)
**10.** Evaluation of the Healthy Okotoks Project
**11.** An Evaluation of Lakeland Regional Health Authority Integrated Community-Based Palliative Care Program
**12.** Primary Health Care Collectives: Improving the Quality of Medication Use in the Community
**13.** Evaluation of the Usefulness of Telehealth in Providing Enhanced Primary Health Services to the Northern, Geographically Remote Communities of Trout Lake, Peerless Lake and Red Earth Creek
**14.** Evaluation of Urban Patients' Choice of an Emergency Department as their First Contact with Primary Care Services
**15.** Evaluation of the Edmonton Centre for Survivors of Torture and Trauma
**16.** Healthy Families - Primary Health Care Services to High Risk Families
**17.** Healthy Families Project - Westview
**18.** What are the Client Characteristics and their Perceived Barriers for Non-Adherence to Immunization Schedules and What Impact will an Immunization Refusal Strategy Have on

Subsequent Adherence at the Six (6) Month, Twelve (12) Month and Eighteen (18) Month Visit?

**19.** Misericordia Health-Lifestyle Improvement Education Centre
**20.** Evaluation of the Northeast Edmonton Community Health Centre (NE CHC)
**21.** A Program Evaluation of Diabetes Centres in the Capital Health Region
**22.** Remote Primary Care System Pilot Project (Rural)
**23.** Evaluation of Shared Mental Health Care in Primary Care Practice
**24.** Developing a Framework for Primary Health Care Delivery - A Study to Support the Repositioning and Practices in the Provision of Primary Health Care
**25.** East Central Health Primary Health Services (PHS) Initiative
**26.** Evaluation of the Alexandra Community Health Centre as a Model of Primary Health Care
**27.** Strengthening Multidisciplinary Teams in Coordinated Disease Prevention and Management

Project summaries and final reports are available.

## Health Innovation Fund

In 1999 the Alberta Government developed a Six-Point Plan for Health, which was further developed by the Alberta Health & Wellness Business Plan. The Six-Point Plan aims to:

1. improve access to quality publicly funded services;
2. improve the management of the health system;
3. enhance the quality of health services;
4. increase the emphasis on promoting wellness for Albertans and preventing disease and injuries;
5. foster new ideas to improve the health system; and
6. protect the publicly-funded health system.

In support of this Plan, the Health Innovation Fund (HIF) was announced by government in March 1999. The purpose of HIF is to promote and facilitate health system reform as well as encourage more effective health service delivery within the province.

In March 2000, Health & Wellness announced funding for 33 projects through the Health Innovation Fund (HIF). These 33 projects were approved based on their ability to:

- Improve the quality and/or efficiency of health services,
- Demonstrate innovative approaches to delivery or introduce a new health service to a different setting
- Capacity for sustainability
- Demonstrate/encourage partnership/collaboration in support of regional and/or provincial business plans
- Be independently evaluated

These 33 projects received a combined total of $7.2 million for 1999/2000 and will run from one to three years.

An additional $8.0 million was allocated for new projects in 2000/2001. The successful projects for this funding will be announced shortly, however, projects will focus on providing health services to individuals or to the larger population. Programs will aim at protecting and promoting health, transitional support for new health services and/or new approaches to delivering health services, including start-up or minor first time renovation costs.

# Projects approved as of March 22, 2000 - Health Innovation Fund Proposal Summaries By Health Region

## Chinook Health Region

Advanced Gerontological Nursing Practice and Surveillance Care for Seniors in Diverse Living Options (Chinook RHA)

An advance practice nurse will help meet the needs of seniors who are currently living in various assisted living residences in the Chinook region.

Chinook Health Region Breast Health Centre (Chinook RHA)

Using a team of health professionals, the Breast Health Center will offer comprehensive breast health services to women within the Chinook Health Region with the goal of reducing breast cancer deaths.

## Palliser Health Region

C.A.R.I.N.G. - Comprehensive Assessment and Rehabilitation of the Individual Needs of Geriatric Clients in the Palliser Health Authority (Palliser RHA)

This joint project with the City of Medicine Hat and Medicine Hat College will provide integrated health services to seniors in the Palliser Health Region to support seniors in the community as long as possible with the objective of delaying or eliminating admission to acute care and community continuing care facilities.

## Calgary Health Region

Comprehensive, Integrated Reproductive and Perinatal Care HIV Positive Women (Calgary RHA)

Using a case management model, this proposal will offer HIV-positive women of childbearing years comprehensive, integrated services to reduce the rate of HIV transmission to their babies and resources to improve contraceptive options.

Primary Care Partnerships: Completing the Health System Through Physician/CHRA Pilot Projects (Calgary RHA)

In collaboration with the Crowfoot Village Family Practice, which is involved in a fee-for-comprehensive care project, this project will further develop the potential for the health management of 13,000+ patients of a six physician practice.

Inner City Medication Access Pilot Project (Calgary RHA and the Alberta Mental Health Board)

This pilot project will provide prescription drugs and education at no cost to the homeless and working poor in Calgary who have little or no access to prescription drugs.

Seniors Grocery Delivery Project (Kerby Centre)

The Kerby Centre of Calgary will provide a home grocery and prescription delivery program to low income, frail, homebound seniors to help maintain or improve their health and allow them to remain in their own homes.

Shared Care Primary Mental Health Care Project for the Homeless (CUPS Community Health Centre and the Alberta Mental Health Board)

This project will provide mental health support services to persons who are homeless and suffering from a mental illness in the east side of downtown Calgary by adding a psychiatrist and social worker to the existing team at the CUPS Community Health Center.

Universal Newborn Hearing Screening Program in Alberta (University of Calgary) – ACTUALLY A PROVINCE WIDE INITIATIVE

In collaboration with regional health authorities, the goal of this proposal is to develop and implement a screening program to identify all infants with hearing loss before three months of age to ensure that these newborns receive the appropriate referrals.

## David Thompson Regional Health Authority

Nurse Practitioner/Physician Collaborative Partnership (David Thompson RHA )

A nurse practitioner will form a partnership with the physicians in the rural-agriculture area of Trochu, Elnora, and Delburne to provide assessment, diagnosis, prescription and healthcare management services to patients.

Medication Management: A Community Medical Clinic Approach (Associate Clinic, Red Deer)

Using a team of community-based physicians and pharmacists, the goal of this project is to identify and reduce drug-related problems and prevent hospital admissions among high-risk patients (the elderly, those with several illnesses or on multiple medications etc.) in the Red Deer community.

## Westview Health Region

Community Youth Health Centre (Tri-Community through Wabamun/Westview RHA)

This project will provide health services to adolescents and young adults from 13 to 25 years of age residing in Stony Plain, Spruce Grove, and Parkland County.

Collaborative Maternity Care Team: Shared Maternity Care

This project will develop a clinic at the Stony Plain Hospital in which a team of physicians, registered midwives, and registered nurses will provide maternal newborn services to low risk maternity clients.

## Crossroads Regional Health Authority

West Pine Lodge Assisted Living Partnership (Crossroads RHA)

This is a pilot project which will provide a flexible range of assisted living arrangements to allow seniors with long term care needs to remain in the West Pine Lodge style of independent living as long as possible.

## Capital Region Health Authority

Adult Brain Injury Caregiver College Program (Capital RHA)

Using an interactive, multimedia educational program, the Caregiver College will provide education, skill development and support to family caregivers of adult brain injury survivors in their home communities (in and outside the Capital Health Region).

Establishment of a Regional Program in Capital Health that Involves the Creation of Hospital Care Teams to Address Clinical Coverage Shortages in Acute Care (Capital RHA)

This project will involve general practitioners, advanced nurse practitioners etc., working collaboratively to better manage the clinical needs of acute care patients and help alleviate existing clinical coverage shortages in acute care.

Grey Nuns Rehabilitation Outreach Service (Capital RHA)

This program will provide affordable wellness rehabilitation programs to support and improve the health of individuals with chronic pain from osteoarthritis and fibromyalgia, diabetes, heart disease, obesity, etc.

Stroke Outreach Education (Capital RHA)

This telehealth program will provide comprehensive care for stroke patients in northern Alberta hospitals in order to improve existing stroke patient management and result in a decrease in transfers of acutely ill stroke patients to the University of Alberta Hospital.

Identification and Delivery of Clinical Preventive Interventions for Patients at Risk at the Royal Alexandra Hospital Emergency Department (Capital RHA)

Using a health risk appraisal software tool, health promotion nurses will identify risk factors in high risk patients (problem drinkers and IV drug users, smokers, women at risk for cervical cancer, etc.) at the Royal Alexandra hospital emergency department and arrange for appropriate referrals.

Active Living for Older Adults (Capital RHA)

This program will deliver fitness/active living programs targeted to older lower income adults who have barriers to accessing fitness programs.

1-800 Critical Care Line - Implementation & Evaluation Team (**Capital and 6 other RHAs**)

The Critical Care Line (a collaboration with six health authorities) will be a central point of entry and link for out-of-region physicians to Capital Health specialists in order to offer timely access to expert advice, speed up early intervention, and assist in the rapid transport of critical care patients into Edmonton hospitals.

An Integrated Model for Primary Health Care and Family Support Service Delivery in Central Edmonton (Capital RHA and Alberta Mental Health Board)

This project will develop a primary health care model that integrates the delivery of health care services provided by Eastwood Public Health Center and other agencies into one community-based site that better serves the Central Edmonton inner city and surrounding neighborhoods.

Community-based Immigrant Mental Health: A Strategic Partnership and Collaboration (Mennonite Centre for Newcomers)

The Mennonite Center for Newcomers will provide mental health services through a network of support and services available to immigrant and refugee families who are at risk or in crisis.

## Aspen Health Region

The Aspen Alzheimer's Cottage (Aspen RHA)

This project will provide specialized nursing, personal care and residential care services for individuals with Alzheimer's disease or dementia in a home-like environment in a duplex cottage.
Aspen Regional Diabetic Program (Aspen RHA)

This project will develop and implement enhanced wellness services for diabetics and their families within the Aspen region.

The Shared Remote Diagnostic Imaging: A Multi-Region Solution (**Aspen and 8 other RHAs)**

Using tele-radiology and video technologies, the goal of this project involving eight RHA's is to significantly improve timely and cost effective access to diagnostic imaging services for patients outside of major urban areas.

## Lakeland Health Region

Metis Health Project (Lakeland RHA)

This project will bring on-site, non-emergency programs and health services to several Metis communities in the Lakeland region to improve their overall health through the use of an on-settlement nurse in a combined role of both public health and home care nurse.

"For Safety's Sake" – A Lakeland Injury Control Initiative (Lakeland RHA)

A regional injury control coordinator and local injury control facilitators will develop and implement injury prevention strategies at the community level.

## Mistahia Health Region

Adult Day Program (VON and Mistahia RHA)

The Victorian Order of Nurses in partnership with Mistahia RHA will offer an Adult Day program to elderly and disabled individuals in Grand Prairie and the surrounding region in order to promote and maintain the health of these individuals.

## Northwestern Regional Health Authority

Telehome Care in Northwestern Health Services Region (Northwestern RHA)

Using electronic technology via telephones lines (e.g. telehome care) in this sparsely populated and geographically isolated region, the goal of this project is to expand, enhance and improve access to homecare services to residents using a homecare nurse to provide cost-effective consultations to clients in their own homes.

## Alberta Cancer Board

Facilitating Seamless Transition to Primary Care Services for Palliative Patients

A palliative care discharge coordinator at the Tom Baker Cancer Centre will provide referral services for regional palliative care programs to terminally ill cancer patients being discharged from the Tom Baker Cancer Centre.

## Other Organizations

Health Innovation: Facilitating the Integration of Registered Midwives as new Health Care Practitioners (Northern Alberta Midwifery Integration Planning Committee, Edmonton)

This project will fund two midwifery implementation coordinators who will facilitate the integration of midwifery services in all 17 Regional Health Authorities.

Transitional Support for the Integration of Midwifery Services in Alberta (Integration of Midwifery Services Evaluation Project Steering Committee, Lacombe)

This project will pay for physician's consultation fees provided to patients of midwives for an interim period of three years and will enable women to have the option of in-hospital midwifery attended births.

### 2nd Call Projects

On February 9, 2000 15 additional projects were selected for funding. These projects selected for funding are looking at innovative ways of improving patient access, integrating services, improving affordability and health outcomes. Projects were selected for funding based on their potential to:

- Demonstrate innovative approaches to delivery or introduce a new health service to a different setting;
- Improve the quality and/or efficiency of health services;
- Capacity for long term sustainability or viability
- Demonstrate/encourage partnership/collaboration in support of regional and/or provincial Business Plans;
- Be independently evaluated.

The 15 funded projects are:

## Calgary

Child Asthma Network (Calgary and Headwaters RHA)

The providers of pediatric asthma care in the Calgary and Headwaters Regions will form a Child Asthma Network to improve the system of services available for children and their families affected by asthma.

Alzheimer's and Dementia Resource Clinic: A Primary Care Approach (Calgary RHA)

This project will implement a clinic using a multidimensional assessment and treatment model for Alzheimer's disease and other dementia patients to organize patient assessment, treatment and care services.

Public Health Services for Children in Government Care (Calgary RHA)

This project will provide a partnership between public health nurses in the Calgary Region and social workers with Calgary Rocky View Child and Family Service Authority in order to deliver selected services to disadvantaged and hard-to-reach children and their families.

Multidisciplinary Primary Care Team Prevention and Management of Chronic Disease (Calgary RHA)

This project aims to use an innovative primary care model in the Calgary Region to deliver a broader range of chronic care to the community.

Interactive Teacher Sexual Health Education Website (Calgary and Headwaters RHA, Calgary Board of Education)

This project will develop an interactive website to be used by all elementary, junior high, and senior high public health teachers in the Calgary and Headwaters Health Regions to enhance teacher comfort and competency in teaching sexual health to students.

Diversion Project (Alberta Mental Health Board, Provincial Court of Alberta, Salvation Army)
This project will divert people with serious mental illness who commit minor, low risk offences from the justice system to the mental health system. Through this project they will receive immediate, accessible care and treatment as an alternative to repeat incarceration.

Outreach Program (Schizophrenia Society of Alberta, Calgary)

This project will help people who have schizophrenia to reintegrate into the community. The personal experiences of people who have schizophrenia and are living productive lives in the community will be studied.

## Edmonton

Bringing the Benefits of an Anticoagulation Management Service to the Community:A Public Health Approach (University of Alberta and Capital RHA)

This community-based project will provide a physician supervised, pharmacist managed service to prevent many blood clotting disorders such as stroke.

Syncrude Gait and Balance Centre (Capital RHA)

The Syncrude Gait and Balance Centre will provide computerized, integrated gait, posture and balance assessment and treatment to Albertans experiencing motor impairments.

Home Nocturnal Hemodialysis Program (Capital RHA)

This project will expand the dialysis services currently offered by the Northern Alberta Renal Program to northern Alberta regional health authorities by providing innovative, cost effective home dialysis services to patients with renal disease who live in rural under serviced areas.

Noninvasive Mechanical Ventilation Reduces Mortality in Chronic Obstructive Pulmonary Disease (Capital RHA)

This project will deliver consistent, state-of-the-art ventilatory support in a rapid, life-saving manner for patients with chronic obstructive pulmonary disease who are admitted into the emergency departments of Capital Health.

Direct Observed Therapy for Delivery of Highly Active Antiretroviral Treatment (HAART) (Boyle McCauley Health Centre, Edmonton)

This project will provide HIV positive patients in the Edmonton inner-city and surrounding area with direct access to therapy, nutritional support and referrals to other relevant health care and social supports.

Do Bugs Need Drugs (Alberta Lung Association, Edmonton and Capital RHA)

This educational approach to increasing awareness about antibiotic resistance and to improve antibiotic usage will work specifically with 340 daycares in Edmonton and 175 day cares in Calgary. Working with Mamowe Family Services Authority in Edmonton and Rockyview Child and Family Resource in Calgary, the target audience is day care children, their parents and day care workers.

Chimo Project (Canadian Mental Health Association, Edmonton SPCA, and Pet Therapy Association of Northern Alberta)

This project will serve as a model for other mental health programs by demonstrating the potential in using companion animals in the treatment of individuals with mental illness.

## Other Regions

Lakeland Centre for Fetal Alcohol Syndrome (Lakeland Fetal Alcohol Syndrome Committee, Cold Lake)

By providing outreach services, this centre will serve the needs of individuals with Fetal Alcohol Syndrome, their families, and the community in which they live.

## AMA Medical Services Budget Innovation Fund

The current agreement between the Alberta Medical Association (AMA) and Alberta Health and Wellness (AHW) includes a $5-million fund for each of the fiscal years 1998-1999 to 2000-2001 to provide one-time support for innovative projects.

To date, some of this funding has been used to support initiatives such as the Relative Value Guide Commission and the Home Care Fee, **and innovative projects proposed by physicians and their health partners**.

The MSB Innovation Fund has been designed to encourage physicians and their partners to deliver or enhance the provision of insured services and/or to enhance patient access to needed care. Physicians were encouraged to collaborate with health partners, such as regional or provincial health authorities in developing their projects.

A total of 27 projects were funded:

## Calgary Regional Health Authority

Assessment of a Multi-Faceted Program for Disseminating a Clinical Practice Guideline: The Management of Children With Croup

This project will develop clinical practice guidelines for the management of children with croup, and will compare whether a more active guideline dissemination process creates better compliance than the current process.

Screening Examination & Telemedicine Capabilities of Using a Digital Retinal Camera in Retinopathy Prematurity

Premature babies have a high chance of having a diseased retina, which is the leading cause of visual loss in school age children. This project will test new technologies (a digital retina camera and electronic photo transfer) and compare this to current methods being used. This project could reduce the transfer of infants to Calgary for the multiple assessments required.

Regional Urgent Neurology Consultation Service

The goal of this project is to reduce waiting times for urgent neurological consultations from four weeks to three to five days by setting up a dedicated clinic. This will provide timely care for patients and reduce visits to emergency departments for neurological assessments.

Does a Spirituality Program Impact on Distressed Individuals – Randomized Controlled Trial

This project will evaluate self-help interventions for patients affected by a high degree of stress, with a goal of providing physicians with more immediate tools to help their patients. The health outcomes for a control group and two different intervention groups will be evaluated.

Creating a Bone and Joint Integrated Health System

This project will optimize bone and joint health care through the development and operation of a single entity dedicated to bone and joint treatment, research and education.

Shared Care Mental Health and the Homeless

The addition of a psychiatrist will enhance the integrated multidisciplinary team coordinated by the CUPS Community Health Centre. This team provides holistic care to the mentally ill homeless, in order to increase access to a range of mental health care services available for this marginalized group.

(This project is being funded in partnership with the Health Innovation Fund)

A Public Medication and Herbal Advice and Information Telephone Service

The services provided by the Poison and Drug Information Service will be enhanced to include advice and information from health professionals about the use of medications and herbal preparations.

Shared Collaborative Mental Health Care in Primary Care

This project expands the Shared Care Project to children and adolescents through the collaborative Mental Health project. The goal is to increase the capacity of the family physicians and community agencies to deal successfully with mental health clients in a primary care setting.

(This is a joint project between the Calgary Regional Health Authority and the Alberta Mental Health Board)

Alexandra Community Health Centre

This project will establish a multi-disciplinary satellite clinic for low-income seniors.

Innovations In Seniors' Care (Primary Care Partnerships)

This project will develop partnerships between community-based family physicians and home care coordinators in order to enhance care of home-bound frail seniors.

## Capital Health Authority

Expenditure Patterns and Costs Associated with Opiate Addiction and a Novel Coedine-Substitution Step-Down Opiate Detoxification Program

This project will assess the costs of the Boyle McCauley Heath Centre detoxification program in terms of directing operating costs, net health care and societal costs, and client costs associated with discontinuing a high-risk lifestyle.

Improving the Quality of Care for Patients with Fractures and Osteoporosis

This project targets patients with osteoporosis that are seen in emergency rooms due to fractures. To enhance secondary management of their osteoporosis, summary clinical practice guidelines for general practitioners and self-care information for patients will be developed and evaluated.

Development & Implementation of a Comprehensive Perioperative Risk Stratification Treatment & Resource Utilization Program for High Risk Patients Undergoing Non-Cardiac Surgery

Clinical pathways will be developed and implemented for patients who are at high risk of developing cardiac and respiratory complications after surgery. The goal of the program is to have a uniform and evidence-based approach to care for these patients, reduce complications and promote appropriate resource utilization.

A Community-Wide Awareness Project for the Wise use of Antibiotics

This project will extend the "Do Bugs Need Drugs?" educational program that was developed in Grande Prairie, to the Capital Health Authority. The program educates the public and health professionals on antibiotic resistance to reduce and optimize the use of antibiotics for respiratory tract infections.

Rapid Access to Information Resources in the Emergency Department: An Evidence Based Approach to Changing Physician Behavior

This project will make evidence-based medical guidelines and care maps available to emergency physicians on computer terminals located at the point of care in the Emergency Department, in order to increase efficiencies, address issues of congestion and improve patient continuity of care.

The Identification of Diabetic Retinopathy by TeleOphthalmology: A Collaborative Project to Improve Diabetic Eye Care

Telehealth will be used to increase the number of eye examinations performed on diabetic patients in the region. The goal of this project is to reduce the advancement of retinopathy, a serious complication of diabetes, in the target population.

(This is a joint project between Northwestern Regional Health Authority and Capital Regional Health Authority)

Preschool Vision Screening in Alberta

An early vision-screening program, where a public health nurse assesses children in licensed daycares and pre-schools, will be implemented in one rural and one urban region. The cost/benefit of this program, especially for the early detection and treatment of amblyopia (commonly known as lazy eye) will be assessed.

(This is a joint project between Northwestern Regional Health Authority and Capital Regional Health Authority)

The Family Practice Quality and Capacity Study (FPQC) (Through U Of A) Dr. David Moores

Bridging the Gap Between Emergency Departments and Primary Care Physicians for Asthma: A Model to Enhance Integrated Asthma Care (Through U of A) Dr. Don D Sin

Community Based Physician Services For Injection Drug Users In The Capital Health Region - Dr. Gerry Predy

Evaluation Of Let Me Decide Program - Dr. John Morrissey

## Crossroads Regional Health Authority

Planning, Organizing and Developing and Integrated Service Delivery Model for Dual Diagnosis /Treatment for Adults in a Regional Health Authority

Approximately 50 to 60 per cent of clients receiving treatment for substance abuse problems through AADAC also have a concurrent psychiatric disorder and would benefit from Alberta Mental Health Board services. The project will identify the services available, gaps, integration opportunities between AADAC and AMHB, and then focus on implementing redesigned programs in the region.

Rural Home-Based Respiratory Rehabilitation

This project will provide and evaluate a home-based respiratory rehabilitation program in a rural health region. Currently, respiratory rehabilitation is available in urban centres only. This program's multidisciplinary team will assist clients in achieving and maintaining their maximum level of independence and functioning in the community.

## David Thompson Regional Health Authority

Nurse Practitioner /Physician Collaborative Partnership

A refinement of the Elnora Primary Health Care Project, that will clarify the roles of physicians and nurse practitioners working in partnership and define the scope-of-practice for nurse practitioners. (This project is being funded in partnership with the Health Innovation Fund)

## Province-Wide

Practice Patterns and Outcomes of Cardiovascular Medicine in Alberta

Through the development of an integrated database for cardiovascular service in Alberta, this project will promote evidence-based medicine in cardiovascular services. This project will address three potential areas for performance enhancement: thrombolytic therapy, catheterization and revascularization procedures and early discharge.

Alberta Trial Prescription Initiative

This project will implement a program to test how a patient tolerates and responds to a new prescribed medication before purchasing a large quantity. The goals of this program are to reduce incidence of drug related problems, to demonstrate efficacy of increased monitoring of new drug therapy and to reduce drug costs by minimizing drug wastage.

Exploration For A Provincial Specialist-Locum Program For Regional/Rural Alberta - Dr. Lawrence Olfert

## Alternative Payment Plans

Alberta Health and Wellness (AHW) and the Alberta Medical Association (AMA) are interested in encouraging innovative, effective and flexible approach to medical care delivery. To this end, they are working together to explore the development of alternative payments plans (APP) with interested physicians. This project is in keeping with the last AHW/AMA agreement and is a continuation of the work begun under the Tripartite alternative funding initiative in 1996.

An Alternate Payment Plan Subcommittee was established to oversee the development of alternative payment plans. Their purpose is to manage all APP matters relating to the AHW/AMA agreement, including development APP funding models and criteria, evaluating APP proposals and facilitating their development. To date, there are five APPs being piloted by Alberta physicians. These are:

Bassano Community Health Centre APP, Bassano, Alberta (started October 1998)
Colonel Belcher Veterans Care Centre (CBVCC), Calgary, Alberta (started October 1999)
Crowfoot Village Family Practice APP, Calgary, Alberta (started November 1999)
Northeast Edmonton Community Health Centre (NECHC) Emergency Department APP, Edmonton, Alberta (started September 1999)
Taber Integrated Primary Care Project, Taber, Chinook Health Authority (started September 1999)

Additional APPs are under discussion with physicians across Alberta.