

Family Practice Quality and Capacity Study

**Report of a Survey of Family Physicians on Issues of
Quality and Capacity in the Capital Health Authority**

January 2002



Department of Family Medicine

University of Alberta

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Executive Summary

The rationale for the Family Practice Quality and Capacity (FPQC) Study comes from the 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. Family physicians play an essential role in the delivery of primary care services. However, system changes and initiatives are frequently undertaken without a thorough discussion with local family physicians to identify issues, challenges, and willingness to participate.

The purpose of the 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.

Eight major issues or themes were identified through a series of focus groups with family physicians in the Capital Health Authority in November and December 2000. Based on the issues identified in the focus groups, a questionnaire was developed and sent to 583 family physicians in the Capital Health Authority in June 2001. A total of 300 questionnaires were completed and returned by the end of August 2001. This report is based on the analysis of those questionnaires. The results are presented according to the sections of the questionnaire.

Summary of Results

Physician Issues

Eleven quotes were identified from the focus groups as being representative of the themes that had emerged. To determine the representativeness of these quotes, physicians were asked to rate their level of agreement with each of the quotes. Overall there was very high level of agreement with the issues identified (79-97% agree/strongly agree for eight of the quotes). Three quotes with lower levels of agreement were thought to have caused confusion for some responders by including more than one theme or issue (25-71% agree/strongly agree).

Access to Specialist Services

Focus group participants had identified that access to specialist services was a major issue, creating stress both for patients and family physicians. The questionnaire asked physicians to identify how strongly they agreed with five statements related to specialist access. There was overwhelming agreement for four of the five statements (*patients should have an identifiable family physician who coordinates access to consultants* [92%], *I need to get my patients seen by a consultant in a more timely fashion* [97%], *I would like access to short verbal consultation with specialists* [86%], and *the referral process needs to be easier and less time consuming* [88%]). The statement *'I need to know my consultants on a personal basis'* received only 61% agree/strongly agree and 32% of the family physicians were neutral on this statement. It appears that for family physicians the key is to get access to specialists. It may be preferable to know the specialists personally, but the need to get the patients seen in a timely manner is critical. The results of this section are supported in the Future Directions section, where family physicians strongly indicate that changes are necessary in order to access specialist services in a more timely and rational manner.

Workload

The hours worked, the number of patients seen, and the number of problems patients' have were felt to be important issues in terms of the quality and capacity of family physicians. In this section, physicians were asked to indicate their current situation and then, what they would like

to see if the system allowed them the opportunity to provide quality care at a level to which they believe a family physician should aspire.

Many family physicians also work long hours in the office doing non-clinical work (documentation and other paperwork), or providing services out-of-office, such as house calls, palliative care, long term and continuing care, and hospital work in addition to being on-call for their practice. This section was not looking at 'how much' or 'how long' physicians work in total during the week. It was looking at clinical practice within the office setting.

In this, and subsequent sections of the questionnaire, physicians were asked to respond with the assumption that the region wished to invest in and support primary care family practice services. They were to assume that they would be well supported, there would be no increase in their overhead expenses and there would be no decrease in their income.

In general, family physicians would like to see fewer patients per hour, spend fewer hours per week doing clinical work in the office, and spend fewer days per week doing clinical work in the office. 54% of family physicians currently see 3-5 patients per hour, 81% of family physicians would like to see 3-5 patients per hour in the future (reducing from 6+ patients per hour).

Scope of Practice

Family physicians were asked to consider in the new and appropriately supported primary health care system described above, how interested they would be in providing a series of identified services. In addition to rating their interest, they were asked to identify if they currently provide the service. The areas that have the highest level of interest from family physicians include, providing comprehensive preventive care (82%), taking part in an on-call group (57%), prenatal care (56%) and palliative care (53%).

The percentage of physicians indicating a 'neutral' level of interest for the identified services varied from 12-27%. The services with the greatest reported levels of neutrality included: long-term care/nursing home care (19%), palliative care (20%), house calls (21%) and care to high intensity, multi-problem patients (27%). These services also had the greatest gaps between the level of interest and the number currently providing the service (i.e. fewer physicians indicating 'interested/very interested' than are currently providing the service).

Primary Care Physician Networks

This section suggested to physicians that one method of providing support to family physicians is through the concept of primary care physician networks. This concept has been identified and publicized by the College of Family Physicians of Canada¹.

The questionnaire described a physician network as being a real or virtual group, practising either in the same office setting or in different locations, but linked with one another to facilitate transfer of information and to share responsibilities. This linkage would be supported through the implementation of electronic information and communications technology.

Physicians were asked to indicate their level of support for each of the items listed. Many of the items identified in this section were in relation to electronic technology. The level of support indicates strongly that family physicians want electronic technology to assist them in quality and capacity related issues. The responses also identify clearly physicians' expectations of what electronic systems should be capable of and what they consider important in an electronic patient record. In the non-electronic technology related items, '*linking with other family physicians*' and '*working in a 24/7 call arrangement*', the level of interest is relatively high but

¹ *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>

not overwhelming (66% and 52% respectively). In both of these items, about 20% of physicians are neutral, with another 4% undecided or no response. It may be that these concepts, and that of a Primary Care Physician Network, are not well known to many family physicians.

Interdisciplinary Collaborative Practice

Focus group participants indicated that there is interest in working collaboratively with other health care professionals. Interdisciplinary collaborative practice could provide benefits both to family physicians and to patients. In the questionnaire, family physicians were asked to indicate their level of interest in working with other health care professionals linked to their practice. They were asked to assume, while responding, that there would be no increase in their overhead expenses and no decrease in their income.

Overall, there is interest from family physicians in working with other health care professionals in a collaborative fashion. Family physicians showed the highest level of interest in working with: dieticians (88% interested/very interested), psychologists (85% interested/very interested), and home care nurses (80% interested/very interested). Following closely behind in level of interest where: pharmacists (78%), physical therapists (78%), office/clinical nurse (77%), and social worker (73%).

Physicians were also asked to indicate if they already have a working relationship with a particular health care professional. The level of interest in working with other health professionals was strikingly higher than the numbers who currently have working relationships with these health professionals. For example, 51% indicate interest in working with a nurse practitioner whereas only 5% currently have a working relationship with a nurse practitioner.

The Complexities and Challenges of Practice

In this section physicians were asked about the usefulness of certain approaches in terms of providing higher quality of care to patients.

The results to *'timely access to diagnostic test results'* (97% indicate useful/very useful) and *'electronic access to test results'* (91% indicate useful/very useful) support the results in the Future Directions section. There is a great desire to have better and more timely access to tests and test results.

94% indicate that it would be useful/very useful to have phone consultations with specialists. This supports the Access to Specialist Services section where 86% indicated they wanted short verbal consultations with specialists. This is further supported in the Future Directions section.

The results for *'access to a social worker'* and *'access to a pharmacist'* mirror the responses in the previous section where we asked interest in working with these health care professionals. Physicians are interested in having access to counselling services (92%) and also in actually working collaboratively (85%) with a psychologist. The need for counselling services is also heavily supported in the Future Directions section.

Triage of patients by other health care professionals shows the lowest level of interest – only 41% of physicians indicated interest. However, 27% were neutral and another 6% undecided or no response. Perhaps further clarification of this concept is necessary for physicians to be interested. Also, the concept of triage by another professional implies teamwork and comfort level with that other professional. This is something that many physicians would not have had experience with.

Future Directions – What Family Physicians See as Necessary

In this section of the questionnaire, physicians were asked to list the five items needed to enhance the quality and capacity of their practice and then rank them in order of priority. In order to facilitate analysis, 98 individual codes were developed. These were then grouped into 13 major categories. The top six categories (access to specialists/consultants, team work/collaborative practice, electronic records/technology, access to diagnostics, time issues and remuneration issues) each have roughly 10 or more percent of the overall total responses. Together they equal 80% of the responses.

Access to specialists/consultants is the first category (21%). Within this category, the top issues are quicker/better access to specialists, consults via the phone with specialists and simplified referrals. *Team work/collaborative practice* follows with 15%. There are a number of issues identified including: nurse on premise (preferably funded), multidisciplinary team paid by region (in office or associated with practice), better access to mental health services, better access to other health care providers (may also include mental health), nurse practitioner in office, ability to delegate more to staff, more extensive access to home care. *Electronic records/technology* is the third category (12%). Basically physicians want electronic technology in their offices, paid for and supported by the system. *Access to diagnostics* comes fourth with just under 12%. The major concerns here are quicker/better access to diagnostic facilities and improved quality of and/or quicker return of lab reports. *Time* issues came fifth in terms of being able to improve quality and capacity with 11%. Physicians want less paperwork and bureaucracy. Some specified more time per patient based on patient need, usually equating it to dollars, so this is closely related to the perceived need for adequate remuneration. Others specified 'more time' without specifying it to patient care. *Remuneration* issues were identified almost 10% of the time. This includes: adequate remuneration in order to compensate for spending appropriate time with patients, adequate remuneration for activities such as long term care and hospital work, and payment for non face-to-face work.

The three individual codes with the highest frequency of response are *quicker/better access to specialists* (16%), *quicker better access to diagnostic facilities* (10%) and *adequate remuneration* (7%).

Conclusions

Family physicians play an essential role in the delivery of primary health care services. The provision of high quality primary health care services by family physicians 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. The FPQC Study has identified issues relating to quality and capacity from the perspective of the family physicians and will facilitate the development of potential strategies to address these issues.

The results of the questionnaire clearly indicate that **family physicians in the CHA are concerned about quality and capacity issues and that they are receptive to trying innovative means of addressing the issues.** However, the physicians indicate that innovations require system changes which cannot occur without the support and participation of stakeholders such as the CHA, Alberta Health & Wellness, the Alberta Medical Association and other health professionals. The level of interest and reflective suggestions provided by physicians in this Study confirms the need for their inclusion in the decision making processes for the development of new ways of practicing. 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 services in the Capital Health Authority will be strengthened.

Introduction

The rationale for the Family Practice Quality and Capacity (FPQC) Study comes from the 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. Family physicians play an essential role in the delivery of primary care services. However, system changes and initiatives are frequently undertaken without a thorough discussion with local family physicians to identify issues, challenges, willingness and ability to participate.

The purpose of the 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.

Based on the results of a series of focus groups held with family physicians in November and December 2000 a questionnaire was developed and sent to family physicians in the Capital Health Authority (CHA). The purpose of this paper is to briefly describe the questionnaire development process and to provide the results of the extensive survey questionnaire.

Methodology

DEVELOPMENT OF THE QUESTIONNAIRE

In May 2001 individuals from various stakeholder groups were identified and asked to participate on a Steering Committee for the FPQC Study. The members of the Steering Committee represent: community based family physicians, academic family physicians, Capital Health Authority, Caritas, Alberta Health & Wellness and the Consortium for Action Research in Primary Care.

The FPQC Steering Committee was asked to review the major themes identified from the physician focus groups and to identify, from the perspective of their individual organizations, any additional issues they wished addressed in the questionnaire.

The FPQC Project Team developed a draft questionnaire, which was circulated to the FPQC Steering Committee for review. Revisions were made based on their review. The questionnaire was then pilot tested with a group of family physicians. Additional modifications were made based on the results of the pilot testing.

FIRST MAILING

The questionnaire was mailed to 583 family physicians in the CHA on June 22, 2001. Included in the package were: an individualized cover letter to the physician, a copy of the questionnaire, and a stamped pre-addressed return envelope. Physicians were asked to respond by July 13, 2001. Physicians were informed that on the back of each questionnaire was a label with an identification number to be used only to track the return of questionnaires. A follow-up reminder was mailed to non-responding physicians on July 6th.

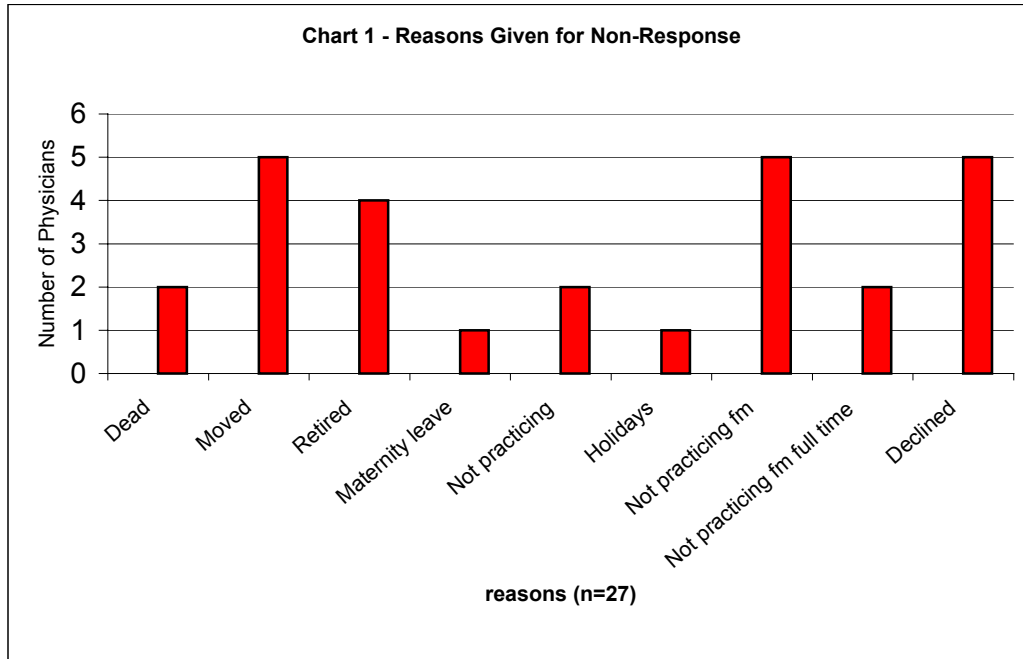
A description of the selection process, and the demographic information on the 583 physicians, is provided in Appendix 1.

SECOND MAILING

A complete second package was mailed to 400 non-responders on July 20th, asking them to return the completed questionnaires by August 10, 2001.

REASONS FOR NON-RESPONSE

In addition to the completed questionnaires that were returned, a number of physicians contacted the Project Team to provide reasons for non-response. The following graph shows the reasons for non-response for 27 physicians (4.6% of the total number of questionnaires sent).



RETURNS

A total of 300 questionnaires were completed and returned by August 31, 2001. These responses form the basis of analysis for this report. Appendix 2 shows the demographic characteristics of the responding physicians.

Results

PHYSICIAN ISSUES

“ More funding is needed to attract more physicians. If we try to increase our capacity and see more patients, a severe sense of time constraint is necessary for the office visits. In this situation we can only focus on the most urgent aspects of the patient visit (the tip of the iceberg). To really be of value in the patients’ care (i.e. quality), some time must be available to probe a little more deeply into the patient’s emotional status, beliefs and lifestyle. The physical symptoms we treat are a reflection of other elements in the patient’s life. Handing out prescriptions is really a ‘minimalist’ approach to ‘treatment’. This doesn’t serve wellness enhancement in the long term. Surely that is the true measure of ‘quality’ care.”

Family Physician

The following eleven quotes were identified from the focus groups as being representative of the themes that had emerged. To determine the representativeness of these quotes, physicians were asked to rate their level of agreement with each of the quotes.

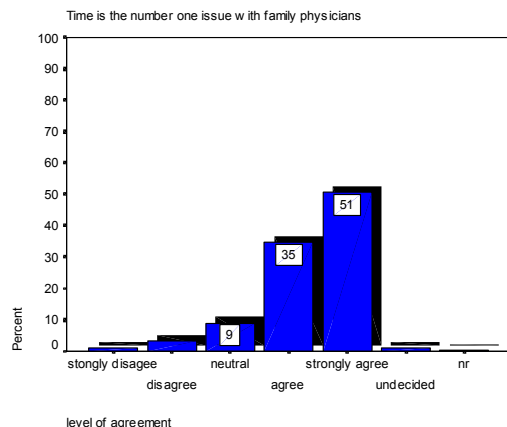
For the most part, the level of agreement with the issues identified was very high, ranging from about 79% to 97%. There were three quotes however that had lower levels of support (see Charts 10, 11, and 12.)

The results from this section were supported in responses to questions in other sections of the questionnaire.

“Time is the number one issue with family physicians.”

86% of physicians agree/strongly agree that time is a major issue. A further 10% are neutral or undecided on this issue.

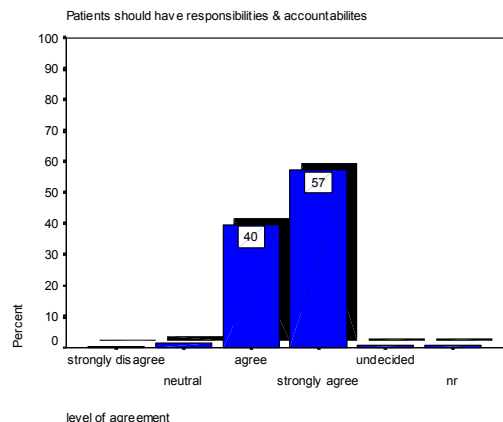
Chart 2



“Patients should have responsibilities and accountabilities within the system.”

97% of physicians agree/strongly agree that patients should be held responsible and accountable within the health system. This is in keeping with the expectation that physicians have responsibilities and accountabilities as well.

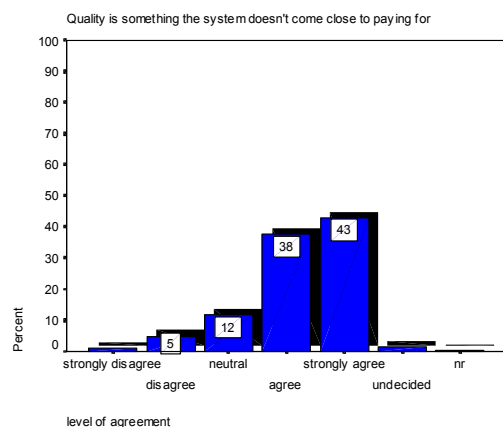
Chart 3



“Quality is something the system absolutely doesn’t come even close to paying for.”

81% of physicians agree/strongly agree that the system does not pay for quality. A further 12% are neutral on the issue. This is particularly in reference to the fee for service system of physician remuneration that rewards volume of services.

Chart 4

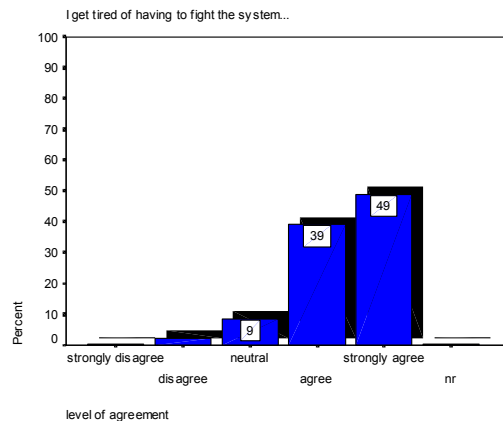


“I get tired of having to fight the system to try to get the facilities and treatment that my patients need.”

88% of physicians agree/strongly agree with this issue.

Trying to make the system work on behalf of patients is time consuming and often emotionally draining. Both from the focus groups, and from the comment section of the questionnaire, it would appear that family physicians see a shift away from ‘direct clinical services’ to spending more time trying to organize tests and consultations.

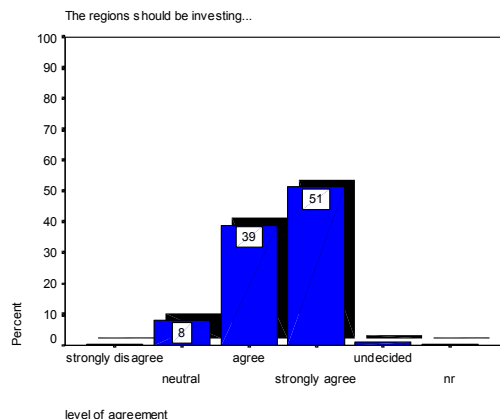
Chart 5



“The regions should be investing in family medicine because we are looking after their citizens in the community.”

90% of physicians agree/strongly agree that the health region should invest more heavily in family medicine/community medicine. Investments in the health service delivery system have been primarily in the secondary and tertiary care sectors.

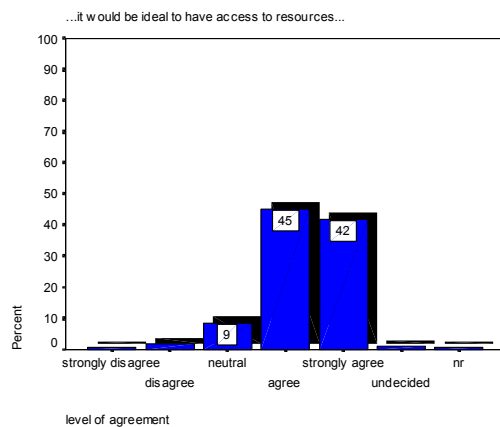
Chart 6



“When we have a complicated patient in the hospital there is no question we are working with that patient as a team. The patients in the office these days are often as complicated as that patient in the hospital... it would be ideal to have access to those same resources.”

87% of physicians agree/strongly agree that they would like to be able to access the same team resources in the community, that they would be able to access in a hospital.

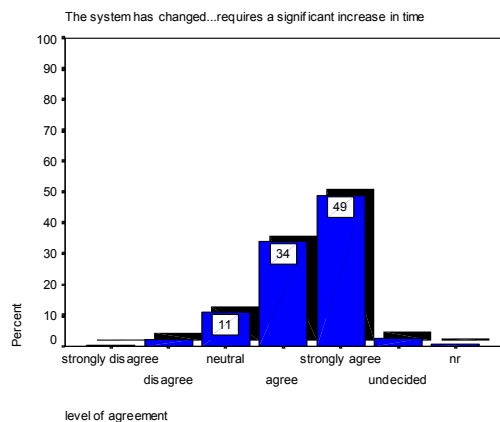
Chart 7



“The system has changed such that to do the same amount of care [as previously done] requires a significant increase in the amount of time.”

83% of physicians agree/strongly agree that providing care to patients takes longer than previously. In the focus groups, participants mentioned this was largely due to increased clinical guidelines, as well as greater expectations on the part of the patients. Evidence based medicine has provided better targets to strive for in terms of patient care.

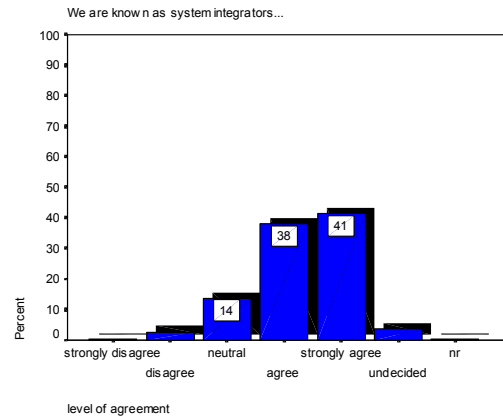
Chart 8



“We are known as ‘system integrators’. That’s what we do all day. The reason that we are a reliable system integrator is because we have a professional ethic that drives us to do that. There is no one else in the system that carries that burden.”

79% of physicians agree/strongly agree with this statement.

Chart 9

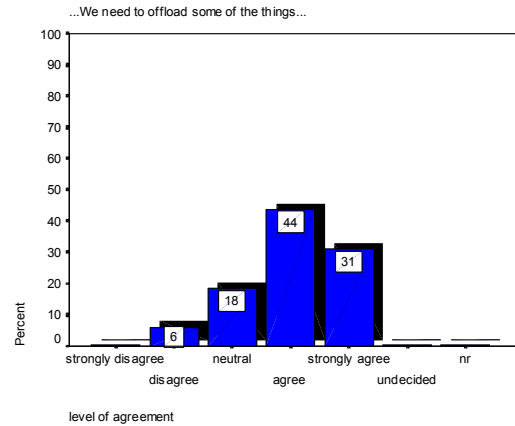


“I spend a lot of my day doing things that I shouldn’t be doing. We need to offload some of the things we do so that we can spend the right time doing the right services for the right patients.”

75% of physicians agree/strongly agree and 19% are neutral or undecided.

This is one of three focus group quotes that possibly caused confusion by having more than one theme or issue involved in the statement.

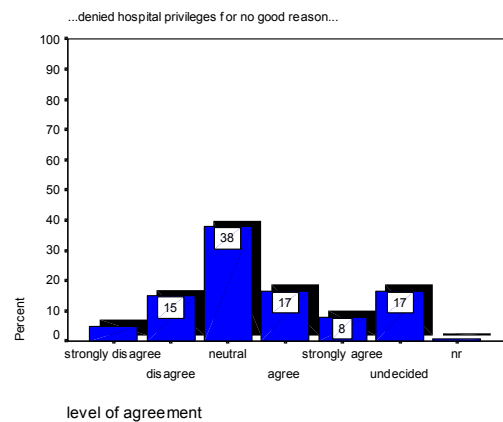
Chart 10



“There is a large group of physicians in the city who were denied hospital privileges for no good reason...who were marginalized.”

This is the second of three quotes that may have more than one theme or issue involved. Again, the distribution of responses is different than in the majority of the quotes. 38% are neutral, with an additional 17% undecided. 20% of physicians disagree/strongly disagree with this quote.

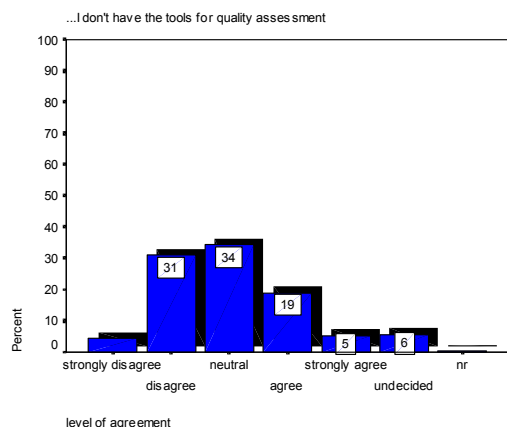
Chart 11



“I’m not sure where I’m at with quality, because I don’t have the tools for quality assessment.”

This is the third of three quotes that has at least two themes in it. This quote has the highest level of disagreement (36% disagree, strongly disagree). An additional 40% of physicians are neutral or undecided about this quote.

Chart 12



ACCESS TO SPECIALIST SERVICES

“Better access to specialists.”

“To facilitate appointments with specialists who are in short supply, it might be useful to consider all referrals going to a central registry who would then arrange the appointments.”

“I have long had a thought that a specialist could be assigned a group of FP/GP’s to “nurture”. To be available for advice, teach as required. There could be some incentive to him for establishing the correct allocation of services, i.e. GP/FP care for all that is reasonable leaving specialist for most appropriate consultation services. Specialists should be paid for phone advice.”

Family Physicians

Focus group participants had identified that access to specialist services was a major issue, creating stress both for patients and family physicians. The questionnaire asked physicians to identify how strongly they agreed with five statements related to specialist access.

The results of the questionnaire certainly support the identification of access to specialists as a key issue for family physicians. Not only in this section, but later in the Future Directions Section, family physicians strongly indicate that changes are necessary in order to access specialist services in a more timely and rational manner.

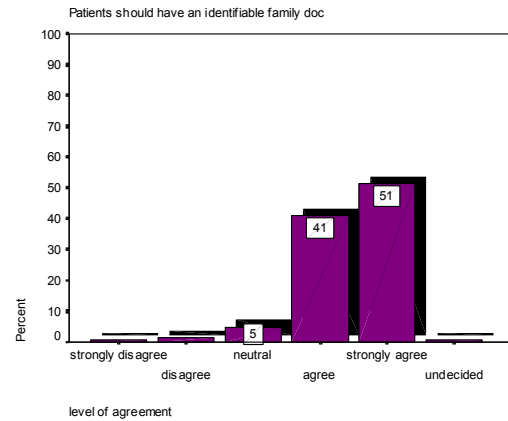
Only one question in this section (“need to know my consultants on a personal basis”) has a large neutral response (32%). It appears that for family physicians the key is to get access to specialists. It may be preferable to know the specialists personally, but the need to get the patients seen in a timely manner is more important.

Patients should have an identifiable family physician who coordinates access to consultants.

92% of family physicians agree/strongly agree that patients should have an identifiable family physician who can help coordinate access to specialists/consultants.

Physician comments indicate that it is relatively common for patients to have more than one family physician involved in their care.

Chart 13

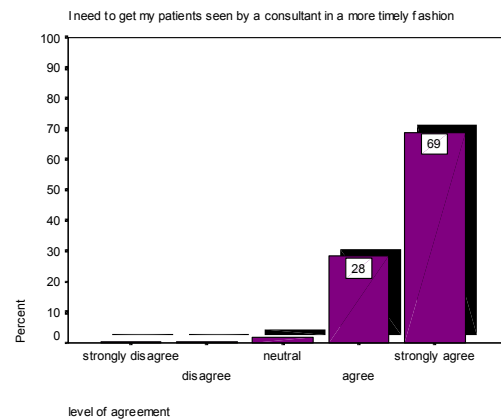


I need to get my patients seen by a consultant in a more timely fashion.

97% of family physicians agree/strongly agree that they need to be able to have patients seen by specialists/consultants in a more timely fashion.

Physicians, both in the focus groups and in subsequent sections of the questionnaire, highlighted the variable time involved in determining if a consultation will occur at all and the length of time before the patient can be seen.

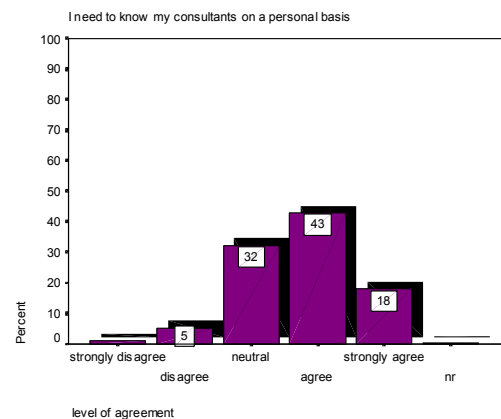
Chart 14



I need to know my consultants on a personal basis.

61% of family physicians agree/strongly agree that they should know the specialists/consultants they refer to on a personal basis. An additional 32% of family physicians are neutral on this.

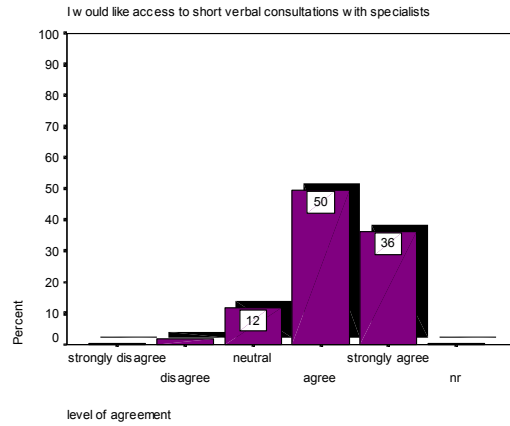
Chart 15



I would like access to short verbal consultations with specialists.

86% of family physicians agree/strongly agree that having short verbal consultations with a specialist (as opposed to referring the patient to the specialist) would be beneficial. This idea is supported in other sections of the questionnaire as well. There is also recognition by the family physicians that there would need to be a mechanism to pay the specialists for this type of interaction.

Chart 16

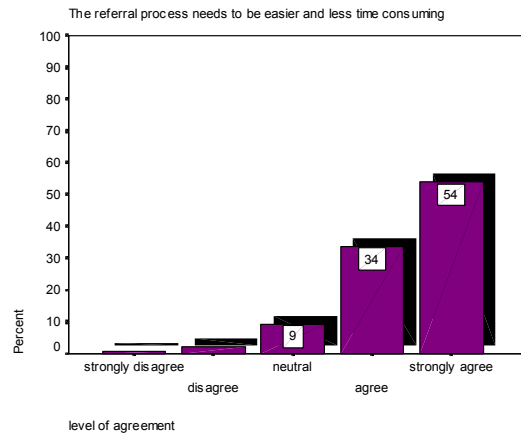


The referral process needs to be easier and less time consuming.

88% of family physicians agree/strongly agree that the referral process to specialists/consultants needs to be easier and less time consuming.

The current process of sending a referral letter or fax, waiting to hear if the consultant will or will not see the patient, and then waiting for the consult to occur, needs to be changed.

Chart 17



WORKLOAD

“I would like to have fewer hours of office work to be able to spend more time on my special interests and development.”

“I would love to be able to take more time off without worrying about overhead and office costs.”

Family Physicians

The hours worked, the number of patients seen, and the number of problems patients' have, were felt to be important issues in terms of the quality and capacity of family physicians. In this section, physicians were asked to indicate their current situation and then, what they would like to see if the system allowed them the opportunity to provide quality care at a level to which they believe a family physician should aspire.

Many family physicians also work long hours in the office doing non-clinical work (documentation and other paperwork), or providing services out-of-office, such as house calls, palliative care, long term and continuing care, and hospital work in addition to being on-call for their practice. This section was not looking at 'how much' or 'how long' physicians work in total during the week. It was looking at clinical practice within the office setting.

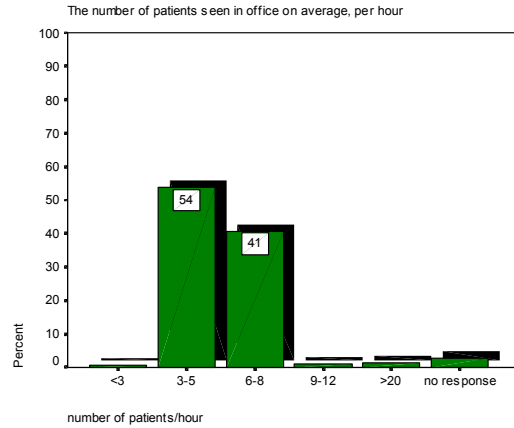
In this, and subsequent sections of the questionnaire, physicians were asked to respond with the assumption that the region wished to invest in and support primary care family practice services. They were to assume that they would be well supported, there would be no increase in their overhead expenses and there would be no decrease in their income.

The number of patients you see in your office on average, per hour

54% of the physicians see between 3-5 patients per hour, and 41% see between 6-8 per hour. 95% of physicians see between 3-8 patients per hour.

There is a significant range in the number of patients seen per hour. It ranges from 1 per hour to 35 per hour. Those physicians who fall within the >20 per hour category may have misinterpreted the question and given a daily figure instead.

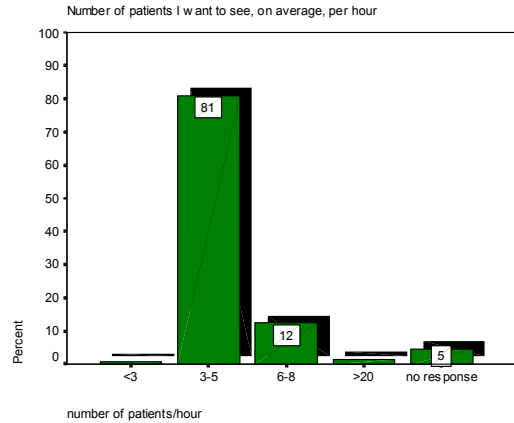
Chart 18



The number of patients you would like to see on average, per hour

81% of the physicians indicate that they would like to see between 3-5 patients per hour. This represents a significant decrease from the current numbers (Chart 18).

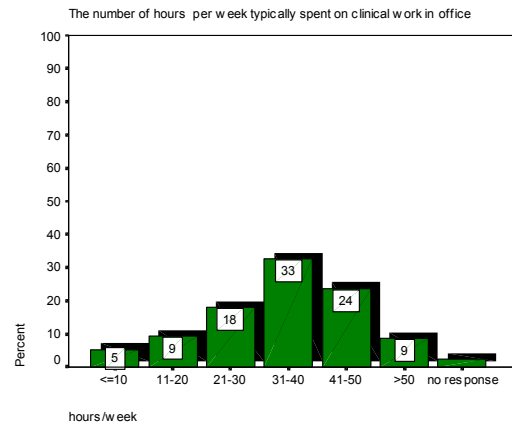
Chart 19



The number of hours per week you typically do clinical work in your office

Again, there is a wide range in the number of hours per week physicians do clinical work within the office. 33% currently work more than 40 hours per week in the office.

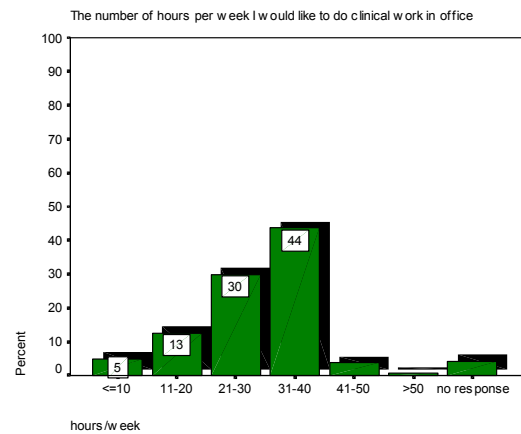
Chart 20



The number of hours per week you would like to do clinical work in your office

The majority of physicians would like to decrease their hours of clinical work. In the future, only 4% would like to work more than 40 hours per week in their offices. This is a decrease of 29% from the current practice.

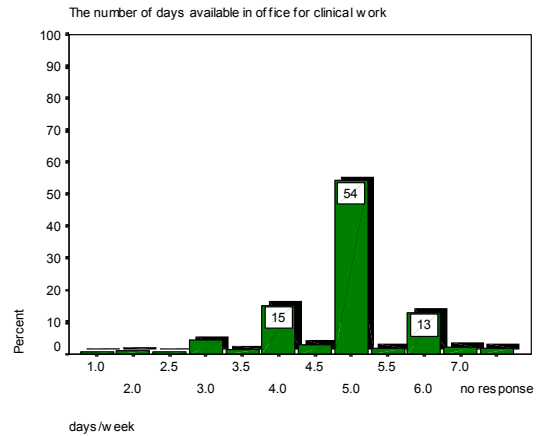
Chart 21



How many days you are available in your office for clinical work

Currently 54% of the family physicians are available in their offices 5 days a week.

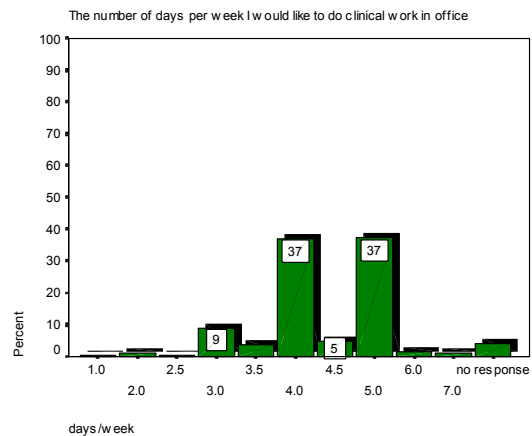
Chart 22



How many days would you like to be available in your office for clinical work

It would appear that most physicians would like to decrease the number of days in the office. In the future 37% of physicians would like to be in the office 4 days a week, with an additional 37% wanting to be in 5 days a week.

Chart 23



SCOPE OF PRACTICE

“I am frustrated by the tendency of the profession to abandon difficult areas of practice and retreat to low needs, low intensity practice. The profession needs to be more involved, not less involved.”

“Community clinics set up and staffed with various disciplines, at which family physicians could practice would be useful.”

Family Physicians

Family physicians were asked to consider how interested they would be in providing a series of identified services in a new and appropriately supported primary health care system in which they would be well supported, with no increase in overhead expenses and no decrease in income. In addition to rating their interest, they were asked to identify if they currently provide the service.

It is interesting to compare the number currently providing a service with those expressing interest in doing so. For instance, ‘taking part in an on-call group’, 71% are currently part of such a group, yet only 57% express interest in doing so, or ‘comprehensive preventive care’ where 62% are currently providing such care, but 82% express interest in doing so.

The areas that have the highest level of interest from family physicians include, providing comprehensive preventive care (82%), taking part in an on-call group (57%), prenatal care (56%) and palliative care (53%).

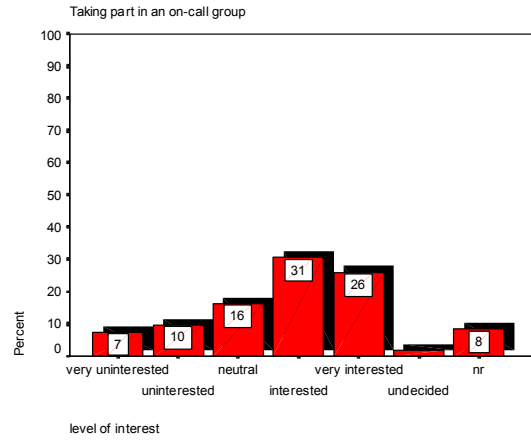
The areas that appear to have the lowest level of interest by family physicians include, in-hospital care for unassigned patients, working as a hospitalist, and intrapartum care. Yet it is important to remember, that for each option listed, there is always a number of family physicians expressing interest in providing that particular type of care.

The percentage of physicians indicating a ‘neutral’ level of interest for the identified services varied from 12-27%. The services with the greatest reported levels of neutrality included: long-term care/nursing home care (19%), palliative care (20%), house calls (21%) and care to high intensity, multi-problem patients (27%). These services also had the greatest gaps between the level of interest and the number currently providing the service (i.e. fewer physicians indicating ‘interested/very interested’ than are currently providing the service).

Interest in taking part in an on-call group

57% of family physicians are interested/very interested in taking part in an on-call group.

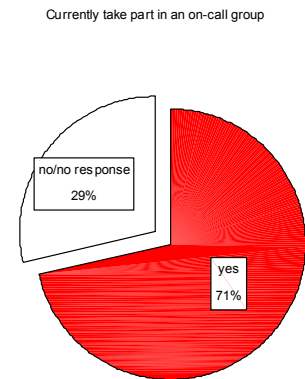
Chart 24a



Currently taking part in an on-call group

71% of family physicians currently take part in an on-call group.

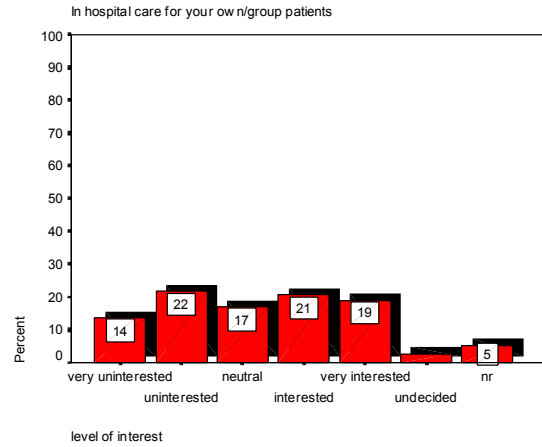
Chart 24b



Interest in providing in-hospital care for your own/group patients

40% of family physicians are interested/very interested in providing in-hospital care for their own (or their groups') patients.

Chart 25a



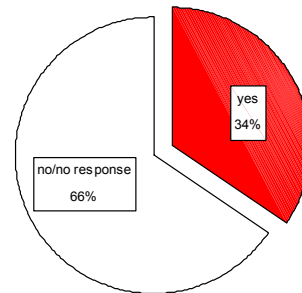
Currently providing in-hospital care for your own/group patients

34% of family physicians currently provide in-hospital care for some portion of their own (or their groups') patients.

This figure may not be reflective of actual practice. Some family physicians admit only a small number of patients to hospital each year and may not provide in-hospital care on an ongoing basis.

Chart 25b

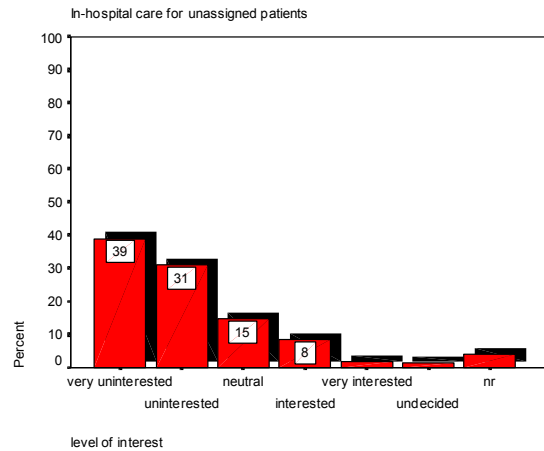
Currently provide in-hospital care for own/group patients



Interest in providing in-hospital care for unassigned patients

9% of family physicians are interested/very interested in providing in-hospital care for unassigned patients.

Chart 26a



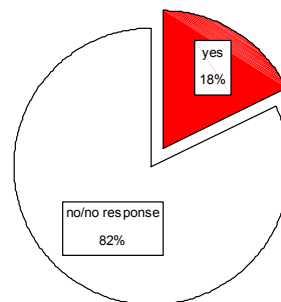
Currently providing in-hospital care for unassigned patients

18% of family physicians currently provide in-hospital care for unassigned patients.

This may reflect a hospital requirement to take on patients of other family physicians or those who don't have a family physician.

Chart 26b

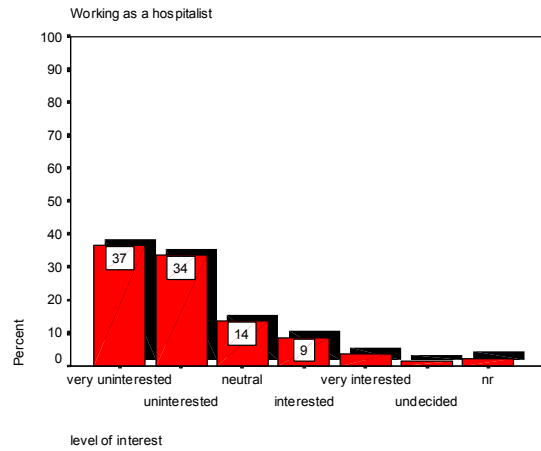
Currently provide in-hospital care for unassigned patients



Interest in working as a hospitalist

13% of family physicians are interested/very interested in working as a hospitalist.

Chart 27a

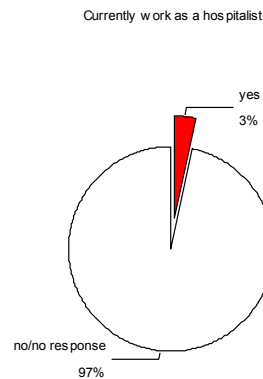


Currently working as a hospitalist

3% of family physicians currently work as hospitalists.

The role of hospitalist is a relatively new one. There are still few opportunities for family physicians to perform this role and this may reflect the small number of physicians working as a hospitalist.

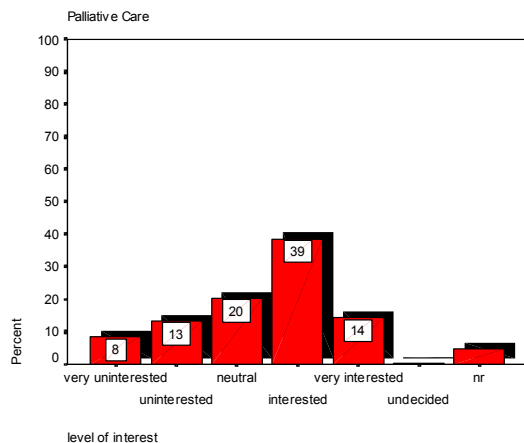
Chart 27b



Interest in providing palliative care

53% of family physicians are interested/
very interested in providing palliative care.

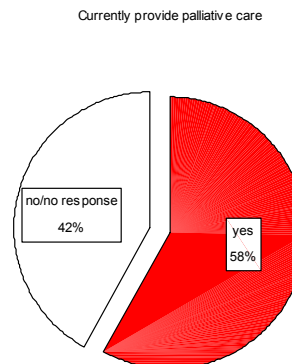
Chart 28 a



Currently providing palliative care

58% of family physicians currently provide
palliative care.

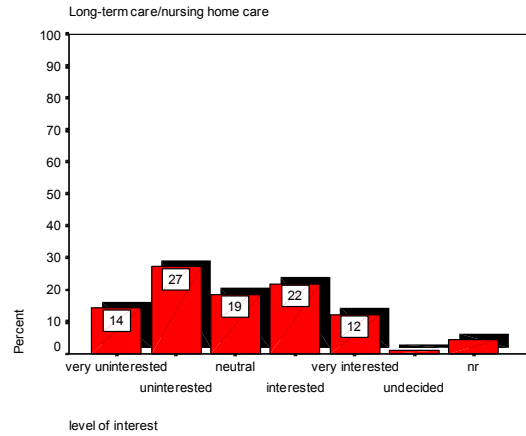
Chart 28b



Interest in long-term care/nursing home care

34% of family physicians are interested/very interested in providing long-term care or nursing home care.

Chart 29a

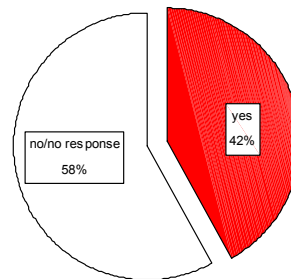


Currently providing long-term care/nursing home care

42% of family physicians currently provide long-term care or nursing home care.

Chart 29b

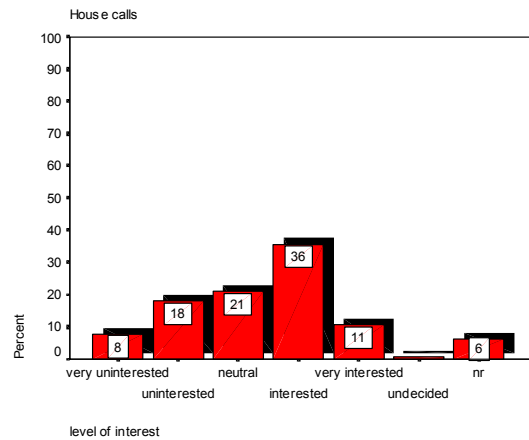
Currently provide long-term care/nursing home care



Interest in providing house calls

47% of family physicians are interested/very interested in providing house calls.

Chart 30a

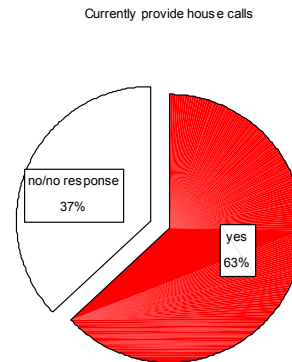


Currently providing house calls

63% of family physicians currently provide house calls.

This figure would include some of the physicians from Chart 28b, who currently provide palliative care. 82% of physicians who provide house calls also provide palliative care.

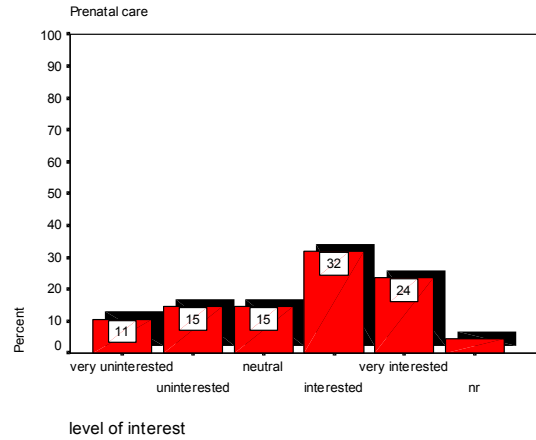
Chart 30b



Interest in providing prenatal care

56% of family physicians are interested/
very interested in providing prenatal care.

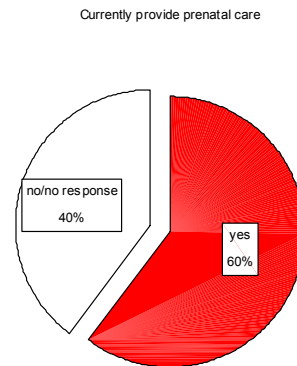
Chart 31a



Currently providing prenatal care

60% of family physicians currently provide
prenatal care.

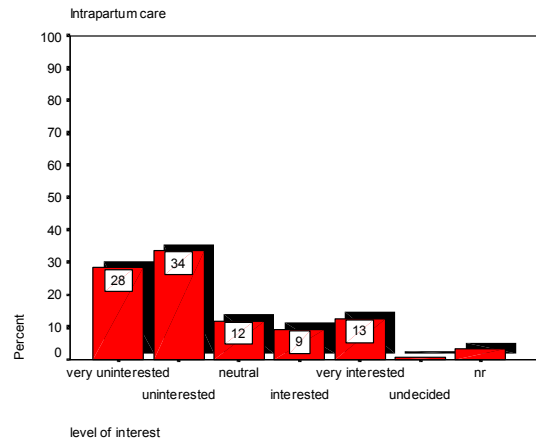
Chart 31b



Interest in providing intrapartum care

22% of family physicians are interested/very interested in providing intrapartum care.

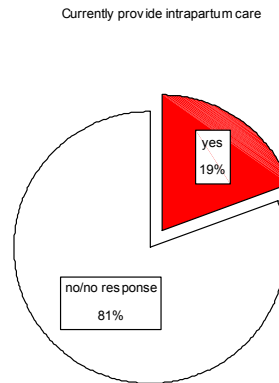
Chart 32a



Currently providing intrapartum care

19% of family physicians currently provide intrapartum care.

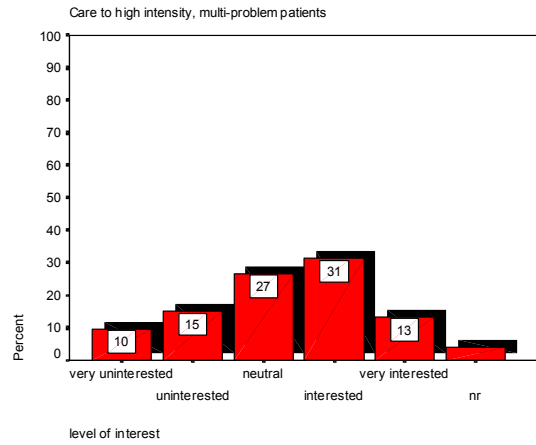
Chart 32b



Interest in providing care to high intensity, multi-problem patients

44% of family physicians are interested/very interested in providing care to high intensity, multi-problem patients.

Chart 33a

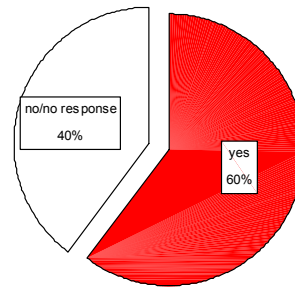


Currently providing care to high intensity, multi-problem patients

60% of family physicians currently provide care to high intensity, multi-problem patients.

Chart 33b

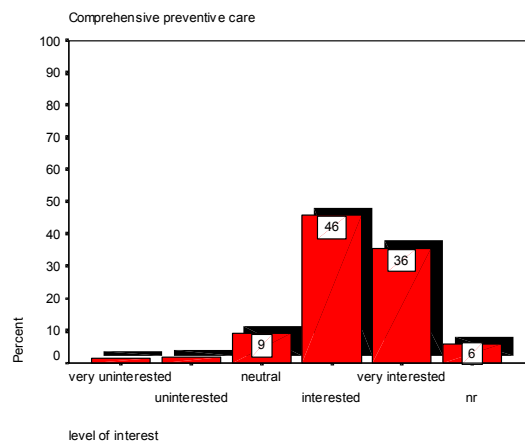
Currently provide care to high intensity, multi-problem patients



Interest in providing comprehensive preventive care

82% of family physicians are interested/very interested in providing comprehensive preventive care.

Chart 34a



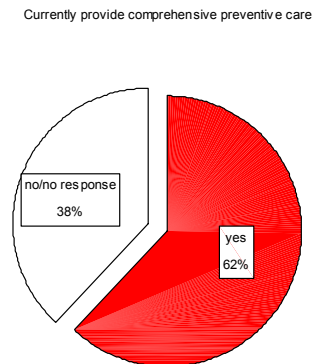
Currently providing comprehensive preventive care

62% of family physicians currently provide comprehensive preventive care.

This may be viewed in relation to charts 18 and 19 where 54% of family physicians currently see 3-5 patients per hour. However, 81% would like to see 3-5 patients per hour, a reduction from 6+ patients per hour.

Providing comprehensive preventive care generally requires more time per patient. This is also supported in the Future Directions section where physicians indicate the need to be adequately remunerated for spending the appropriate time with patients.

Chart 34b



PRIMARY CARE PHYSICIAN NETWORKS

“Networks, both electronic and between physicians, are vital.”

Family Physician

This section suggested to physicians that one method of providing support to family physicians is through the concept of primary care physician networks. This concept has been identified and publicized by the College of Family Physicians of Canada¹.

The questionnaire described a physician network as being a real or virtual group, practising either in the same office setting or in different locations, but linked with one another to facilitate transfer of information and to share responsibilities. This linkage would be supported through the implementation of electronic information and communications technology.

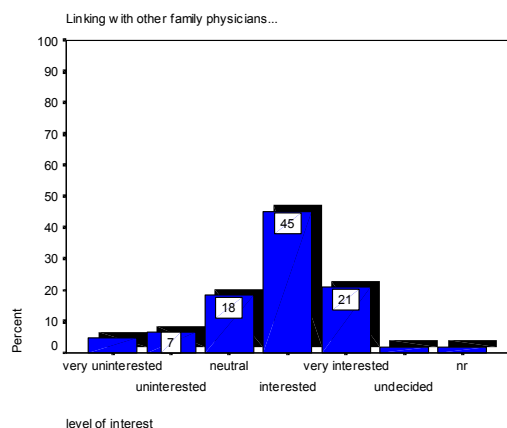
Physicians were asked to indicate their level of support for each of the items listed. Many of the items identified in this section were in relation to electronic technology. The level of support indicates strongly that family physicians want electronic technology to assist them in quality and capacity related issues. The responses also identify clearly physicians' expectations of what electronic systems should be capable of and what they consider important in an electronic patient record.

In the non-electronic technology related items, 'linking with other family physicians' and 'working in a 24/7 call arrangement', the level of interest is relatively high but not overwhelming (66% and 52% respectively). In both of these items, about 20% of physicians are neutral, with another 4% undecided or no response. It may be that these concepts, and that of a Primary Care Physician Network, are not well known to many family physicians.

Linking with other family physicians to collectively provide a full range of family practice services

66% of physicians are interested/very interested in linking with other family physicians to collectively provide a full range of family practice services.

Chart 36

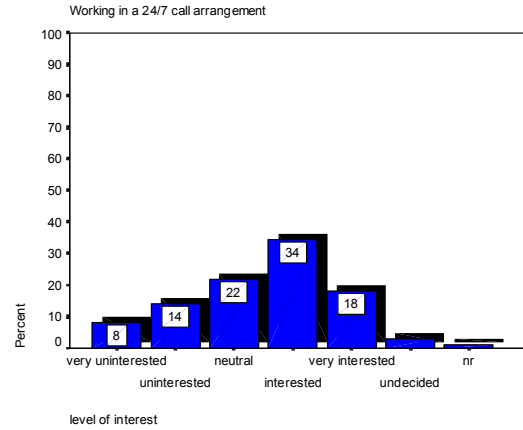


¹ *Primary Care and Family Medicine in Canada – A Prescription for Renewal*, College of Family Physicians of Canada; October 2000; <http://www.cfpc.ca/prescription-oct00.htm>

Working in a 24/7 call arrangement with other family physicians

52% of physicians are interested in working in a 24/7 call arrangement with other family physicians.

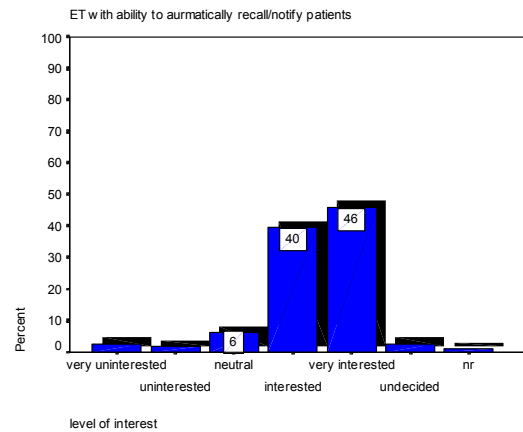
Chart 37



Automatically Recall/Notify Patients

86% of physicians are interested/very interested in electronic technology with the ability to automatically recall or notify patients.

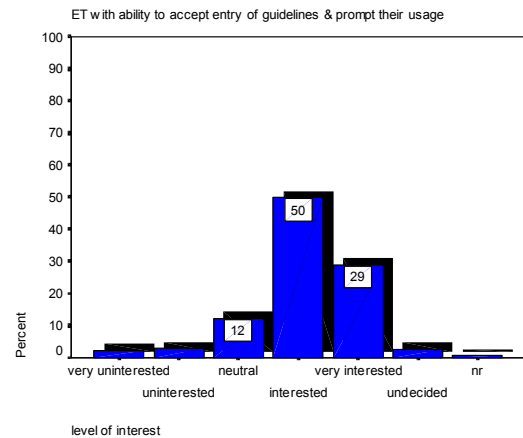
Chart 38



Accept Entry of Guidelines and Prompt Their Usage

79% of physicians are interested/very interested in electronic technology with the ability to selectively integrate guidelines, and to prompt physicians in their usage of the guidelines.

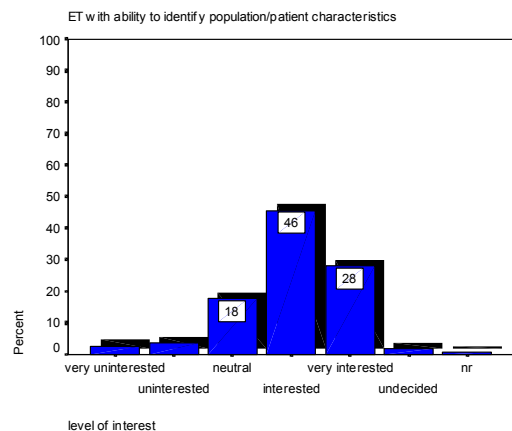
Chart 39



Identify Population/Patient Characteristics

74% of physicians are interested/very interested in electronic technology with the ability to identify the characteristics of their patient population.

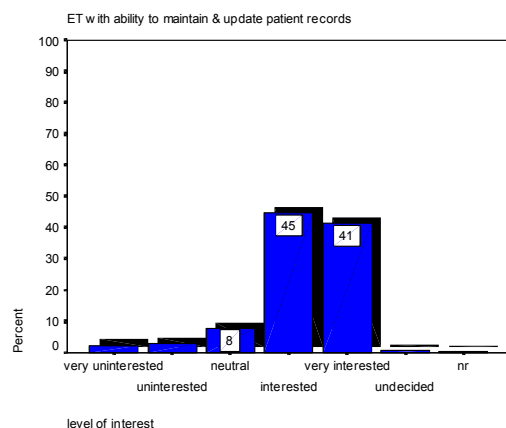
Chart 40



Maintain and Update Patient Records

86% of physicians are interested/very interested in electronic technology with the ability to maintain and update patient records.

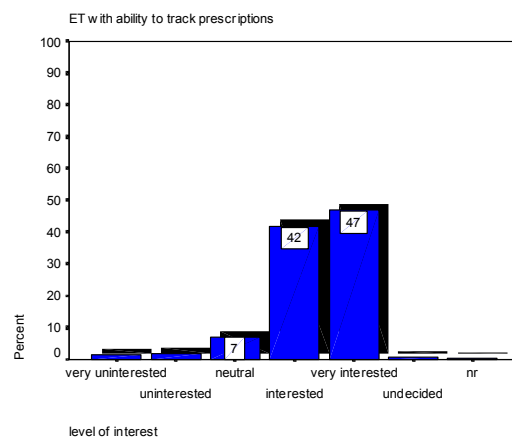
Chart 41



Track Prescriptions

89% of physicians are interested/very interested in electronic technology with the ability to track prescriptions.

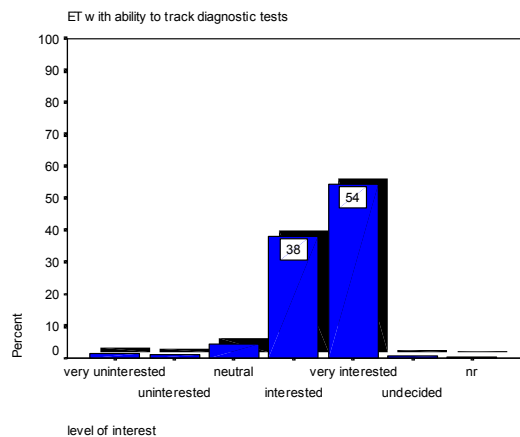
Chart 42



Track Diagnostic Tests

92% of physicians are interested/very interested in electronic technology with the ability to track diagnostic tests.

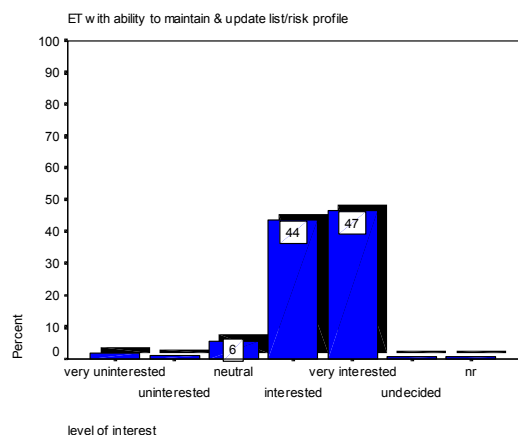
Chart 43



Maintain and Update Problem List/Risk Profile

91% of physicians are interested/very interested in electronic technology with the ability to maintain and update problem lists or risk profiles of patients.

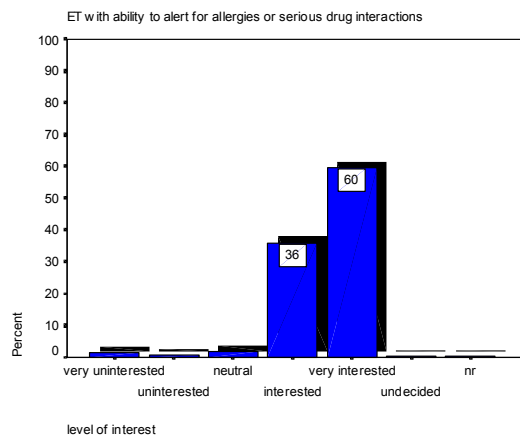
Chart 44



Alert for Allergies or Serious Drug Interactions

96% of physicians are interested/very interested in electronic technology with the ability to alert for allergies or serious drug interactions.

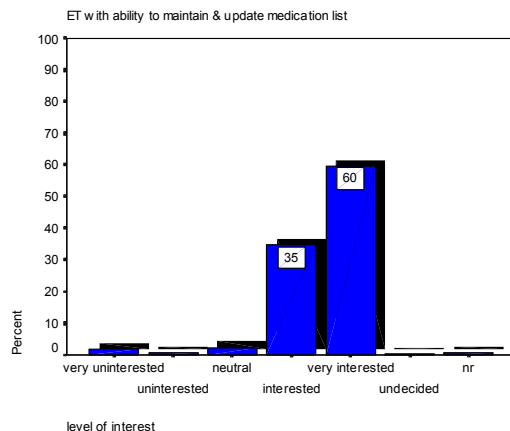
Chart 45



Maintain and Update Medication List

Chart 46

95% of physicians are interested/very interested in electronic technology with the ability to maintain and update medication lists.



INTERDISCIPLINARY COLLABORATIVE PRACTICE

“Capacity increase could be addressed by the addition of nurse practitioners for less complex problems, but that would mean better compensation for difficult cases would be necessary in our current payment scheme.”

“Triage of patients, physician assistants, clerical assistants with paperwork, access to specialists, electronic patient records, pharmacy, labs and x-ray.”

Family Physicians

Focus group participants indicated that there is interest in working collaboratively with other health care professionals. Interdisciplinary collaborative practice could provide benefits both to family physicians and to patients. In the questionnaire, family physicians were asked to indicate their level of interest in working with other health care professionals linked to their practice. They were asked to assume, while responding, that there would be no increase in their overhead expenses and no decrease in their income.

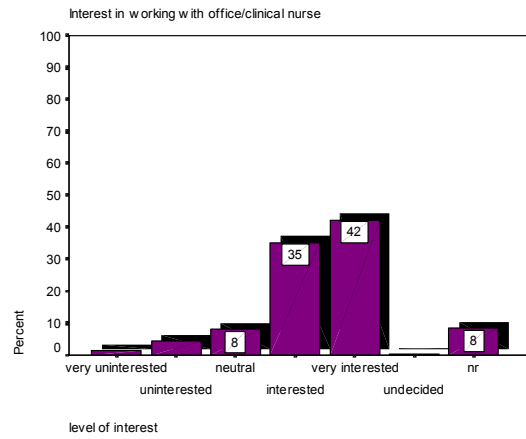
Overall, there is interest from family physicians in working with other health care professionals in a collaborative fashion. Family physicians showed the highest level of interest in working with: dietitians (88% interested/very interested), psychologists (85% interested/very interested), and home care nurses (80% interested/very interested). Following closely behind in level of interest were: pharmacists (78%), physical therapists (78%), office/clinical nurses (77%), and social workers (73%).

Physicians were also asked to indicate if they already have a working relationship with a particular health care professional. The detail of these relationships was not specified. The level of interest in working with other health professionals was strikingly higher than the number who currently have working relationships with these health professionals. For example, 51% indicate interest in working with a nurse practitioner whereas only 5% currently have a working relationship with a nurse practitioner.

Interest in working with an office/clinical nurse

77% of physicians are interested/very interested in working with an office nurse/clinical nurse.

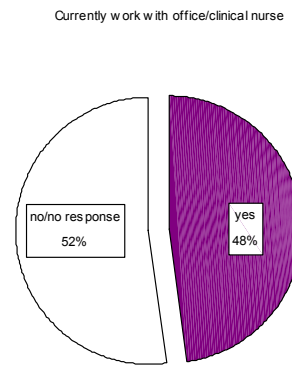
Chart 48a



Currently work with an office/clinical nurse

48% of physicians currently work with an office/clinical nurse.

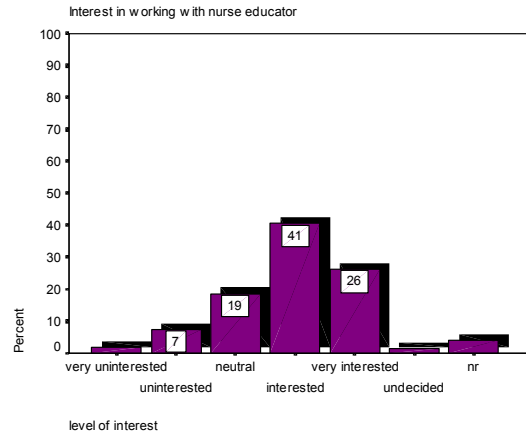
Chart 48b



Interest in working with a nurse educator

67% of physicians are interested/very interested in working with a nurse educator.

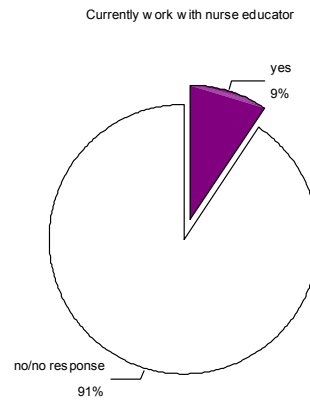
Chart 49a



Currently work with a nurse educator

9% of physicians currently work with a nurse educator.

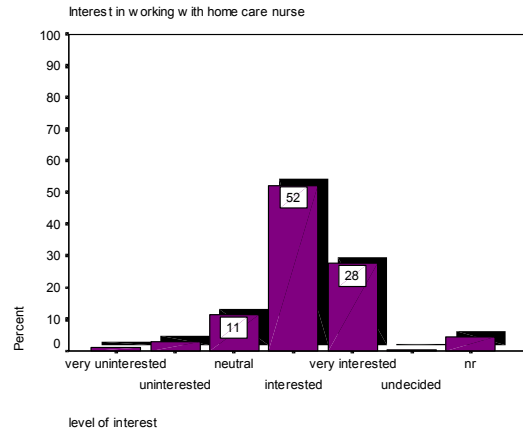
Chart 49b



Interest in working with a home care nurse

80% of physicians are interested/very interested in working with a home care nurse.

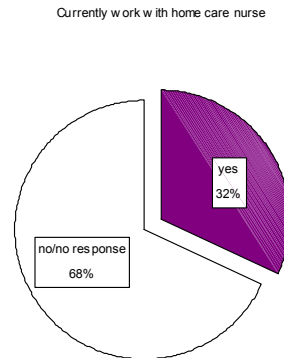
Chart 50a



Currently work with a home care nurse

32% of physicians currently work with a home care nurse.

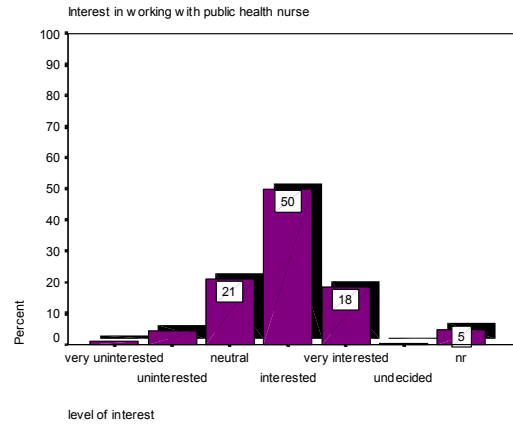
Chart 50b



Interest in working with a public health nurse

68% of physicians are interested/very interested in working with a public health nurse.

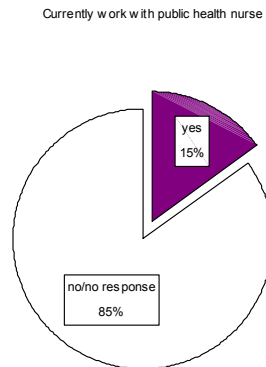
Chart 51a



Currently work with a public health nurse

15% of physicians currently work with a public health nurse.

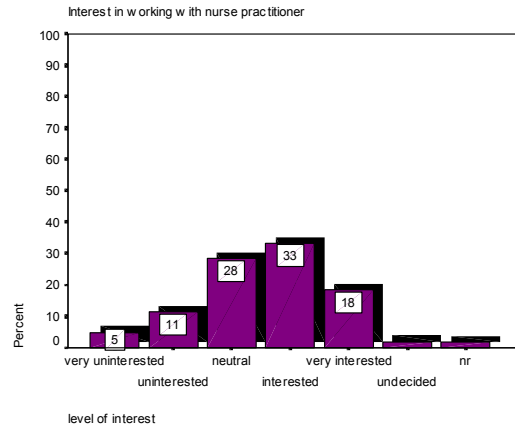
Chart 51b



Interest in working with a nurse practitioner

51% of physicians are interested/very interested in working with a nurse practitioner.

Chart 52a



Currently work with a nurse practitioner

5% of physicians currently work with a nurse practitioner.

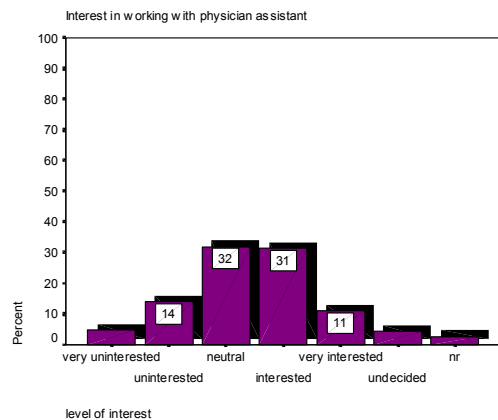
Chart 52b



Interest in working with a physician assistant

42% of physicians are interested/very interested in working with a physician assistant.

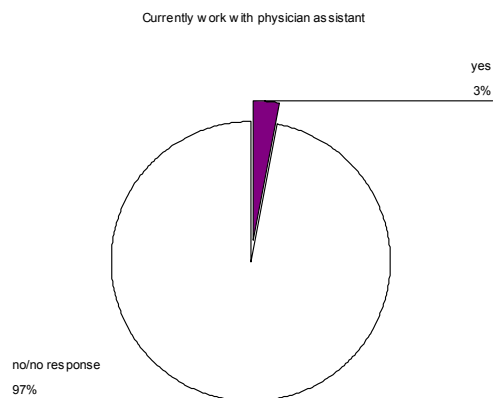
Chart 53a



Currently work with a physician assistant

3% of physicians currently work with a physician assistant.

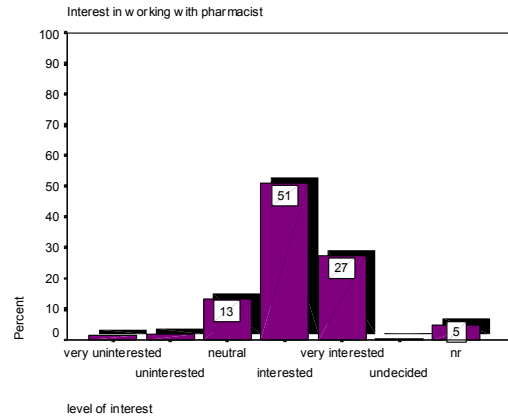
Chart 53b



Interest in working with a pharmacist

Chart 54a

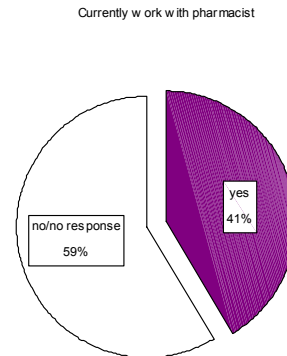
78% of physicians are interested/very interested in working with a pharmacist.



Currently work with a pharmacist

Chart 54b

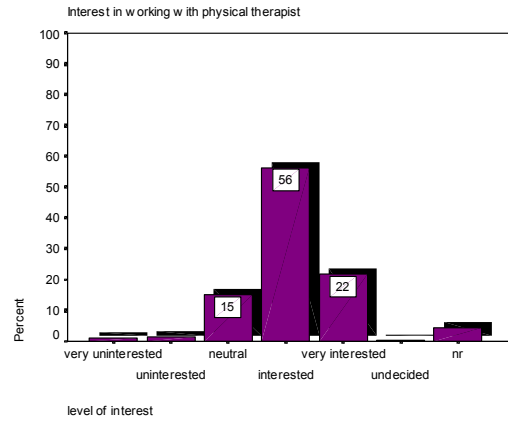
41% of physicians currently work with a pharmacist.



Interest in working with a physical therapist

78% of physicians are interested/very interested in working with a physical therapist.

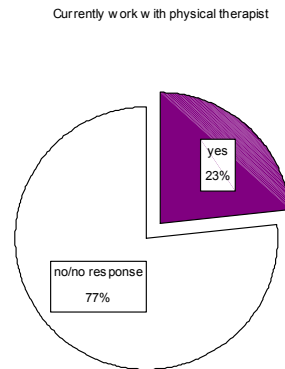
Chart 55a



Currently work with a physical therapist

23% of physicians currently work with a physical therapist.

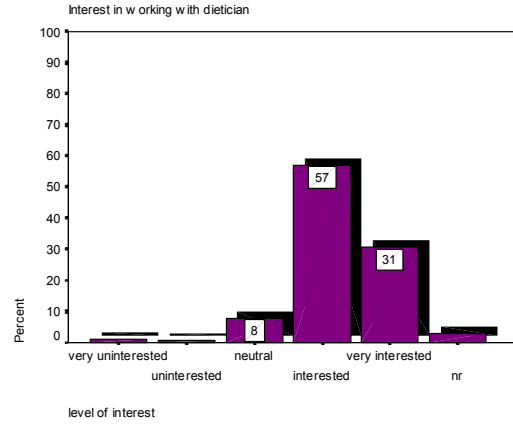
Chart 55b



Interest in working with a dietician

Chart 56a

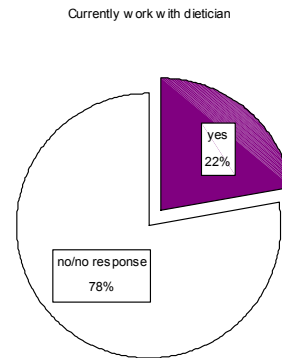
88% of physicians are interested/very interested in working with a dietician.



Currently work with a dietician

Chart 56b

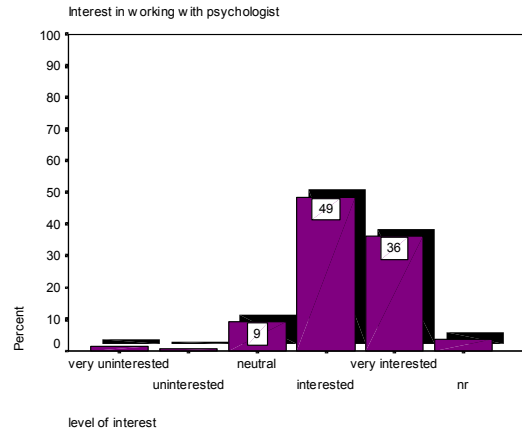
22% of physicians currently work with a dietician.



Interest in working with a psychologist

Chart 57a

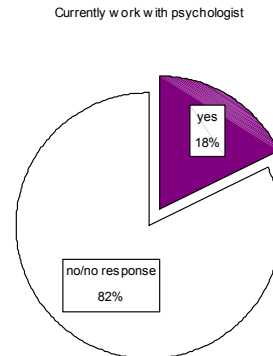
85% of physicians are interested/very interested in working with a psychologist.



Currently work with a psychologist

Chart 57b

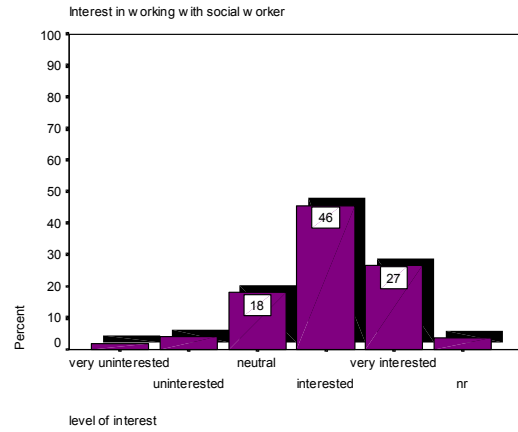
18% of physicians currently work with a psychologist.



Interest in working with a social worker

73% of physicians are interested/very interested in working with a social worker.

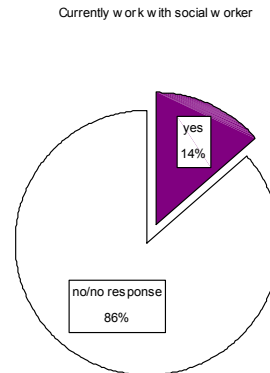
Chart 58a



Currently work with a social worker

14% of physicians currently work with a social worker.

Chart 58b



THE COMPLEXITIES AND CHALLENGES OF FAMILY PRACTICE

“The CHA needs to recognize family practice as an integral component in the efficient and effective delivery of health care in the region. Accordingly, it would be wise for CHA to invest in developing the services offered in family physicians, and it would be wise to include family physicians in decision making and even administration of community health programs.”

Family Physician

In this section physicians were asked about the usefulness of certain approaches in terms of providing higher quality of care to patients.

The results to ‘timely access to diagnostic test results’ (97% indicate useful/very useful) and ‘electronic access to test results’ (91% indicate useful/very useful) support the results in the Future Directions section. There is a great desire to have better and more timely access to tests and test results.

94% indicate that it would be useful/very useful to have phone consultations with specialists. This supports the Access to Specialist Services section where 86% indicated they wanted short verbal consultations with specialists. This is further supported in the Future Directions section.

The results for ‘access to a social worker’ and ‘access to a pharmacist’ mirror the responses in the previous section where we asked interest in working with these health care professionals.

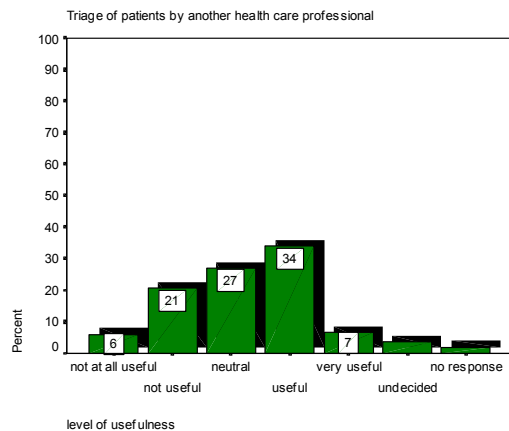
Physicians are interested in having access to counselling services (92%) and also in actually working collaboratively (85%) with a psychologist. The need for counselling services is also heavily supported in the Future Directions section.

Triage of patients by other health care professionals shows the lowest level of interest – only 41% of physicians indicated interest. However, 27% were neutral and another 6% undecided or no response. Perhaps further clarification of this concept is necessary for physicians to be interested. Also, the concept of triage by another professional implies teamwork and comfort level with that other professional. This is something that many physicians would not have had experience with.

Triage of your patients by another health care professional

41% of family physicians consider having their patients triaged by another health care professional to be useful/very useful.

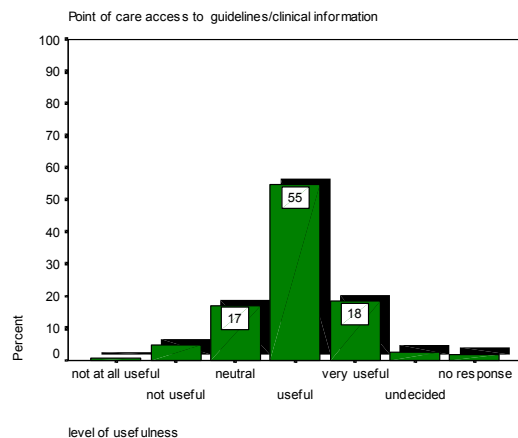
Chart 60



Point of care access to guidelines/clinical information

73% of family physicians consider having point of care access to guidelines/clinical information to be useful/very useful.

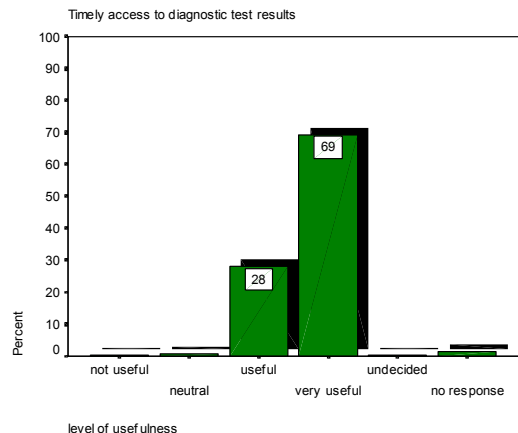
Chart 61



Timely access to diagnostic testing

97% of family physicians consider having timely access to diagnostic testing to be useful/very useful.

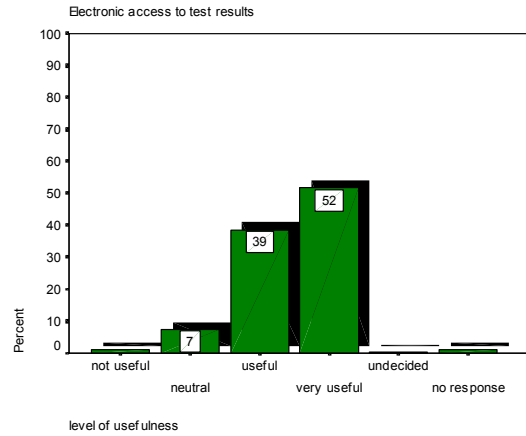
Chart 62



Electronic access to test results

91% of family physicians consider having electronic access to test results to be useful/very useful.

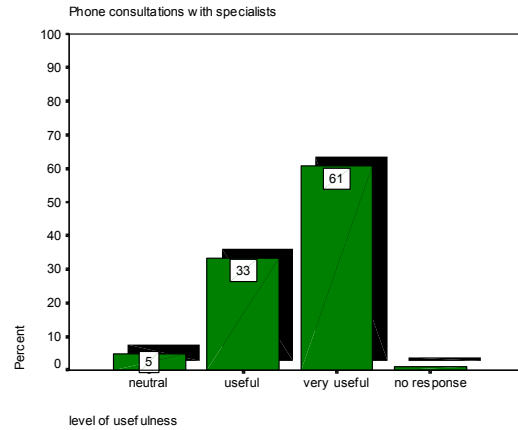
Chart 63



Phone consultation with specialists

94% of family physicians consider having phone consultation with specialists to be useful/very useful.

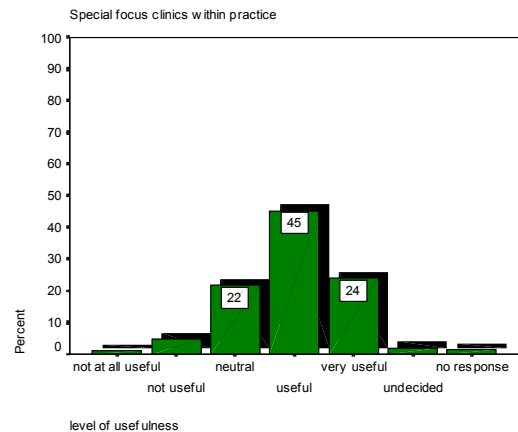
Chart 64



Special focus clinics within your practice

69% of family physicians consider having special focus clinics within their practices to be useful/very useful.

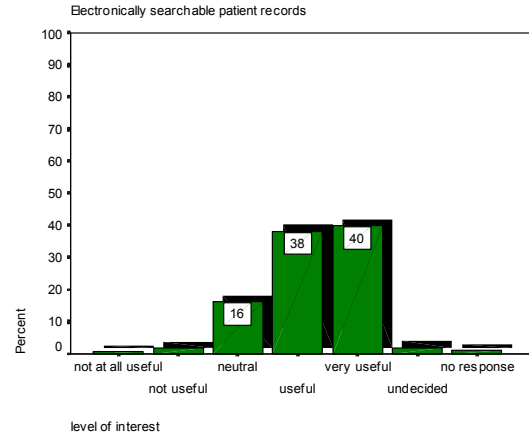
Chart 65



Electronically searchable patient records

78% of family physicians consider having electronically searchable patient records to be useful/very useful.

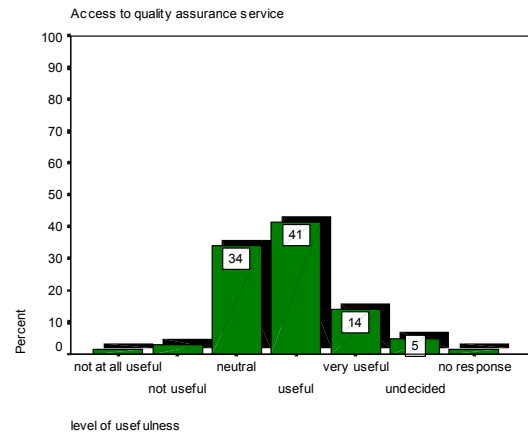
Chart 66



Access to a quality assurance service

55% of family physicians consider having access to a quality assurance service to be useful/very useful.

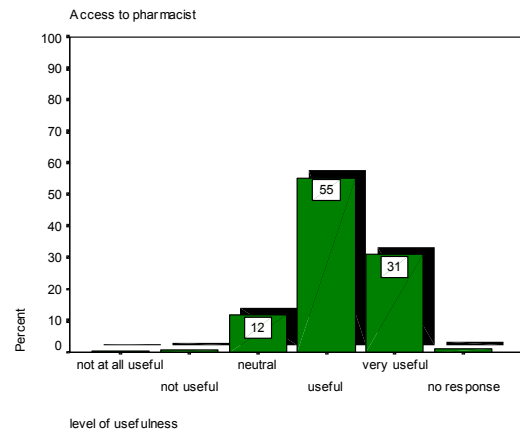
Chart 67



Access to a pharmacist

86% of family physicians consider having access to a pharmacist to be useful/very useful.

Chart 68

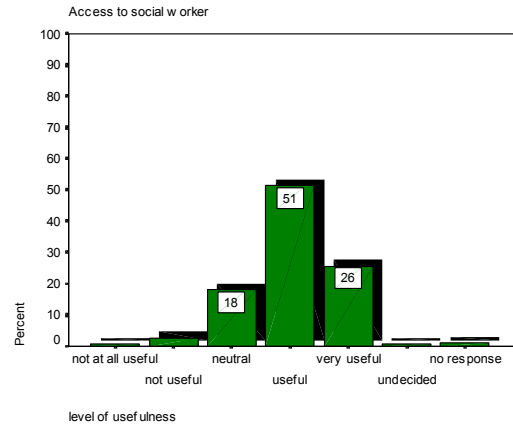


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Access to a social worker

77% of family physicians consider having access to a social worker to be useful/very useful.

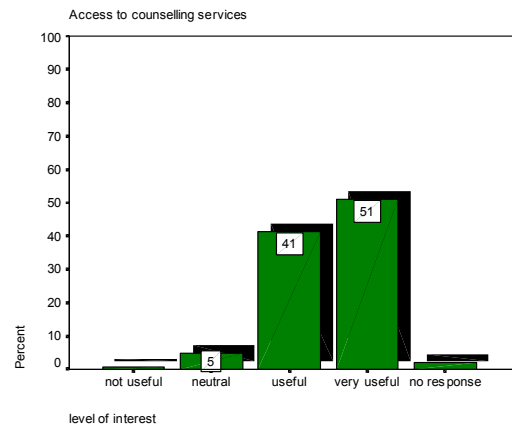
Chart 69



Access to counselling services

92% of family physicians consider having access to counselling services to be useful/very useful.

Chart 70



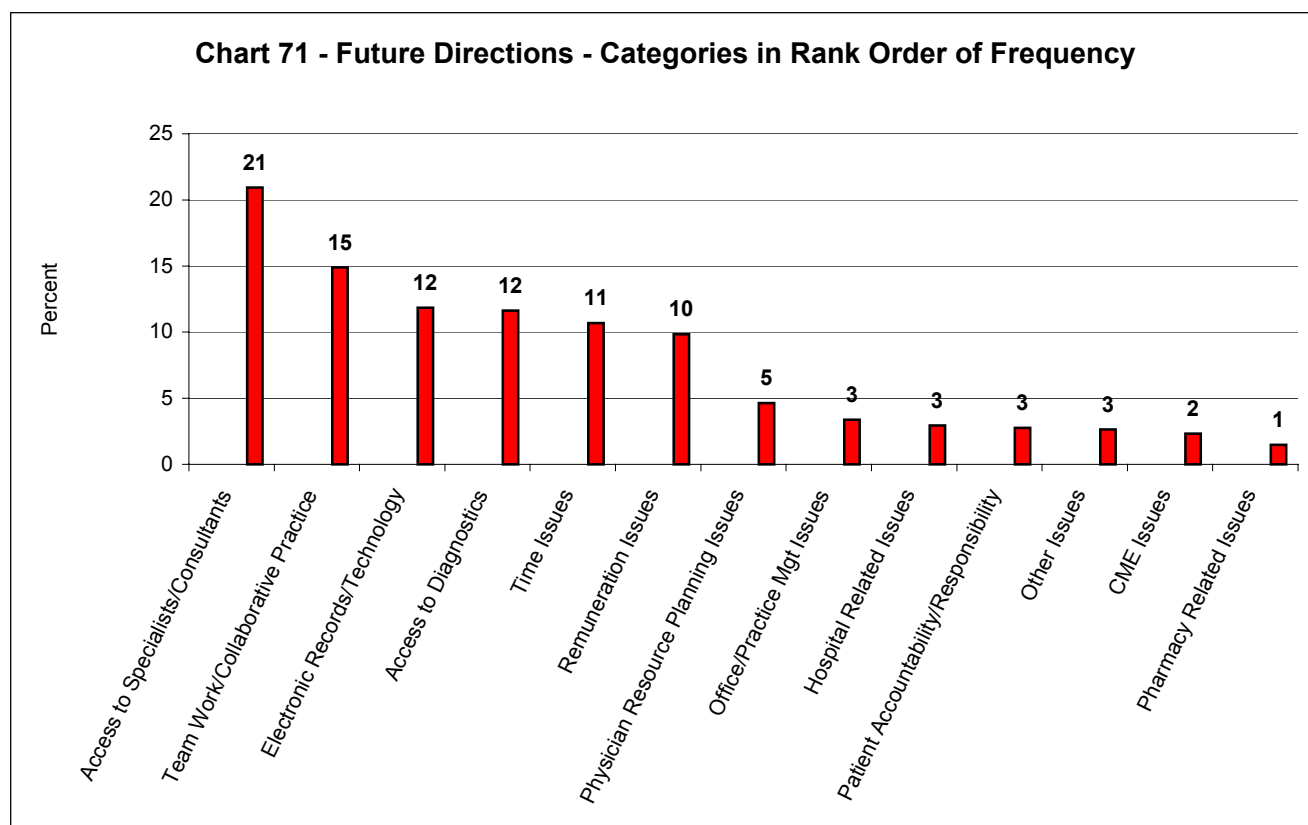
FUTURE DIRECTIONS – WHAT FAMILY PHYSICIANS SEE AS NECESSARY

“We family doctors need help. We’ve been neglected, ignored and discounted far too long by our specialist colleagues and the system. The institutionalized disrespect by the acute care sector (hospitals) in terms of failing to notify us of patient admissions, patient deaths and discharge planning; and limiting our access to resources (beds, tests, consultants, nurses and all the special support services) in the system is very demoralizing. Canada has a two tier health care system in terms of where the monies are spent and the access to the tools to do what we’ve been educated and trained to do. Stereotypes about how easy and inconsequential family practice and primary care are, pervade our medical schools and post-graduate training programs, particularly in the specialities.”

“Remove volume driven practice. Reward good quality care of complicated patients. Pay MDs for vacation. Increase money for CME events. Reward research and innovation.”

Family Physicians

In this section of the questionnaire, physicians were asked to list the five items needed to enhance the quality and capacity of their practice and then rank them in order of priority. In order to facilitate analysis, 98 individual codes were developed. These were then grouped into 13 major categories. Chart 72 shows these categories in rank order of frequency.



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The items identified in this section of the questionnaire clearly support the results of previous sections.

The top six categories (access to specialists/consultants, team work/collaborative practice, electronic records/technology, access to diagnostics, time issues and remuneration issues) each have roughly 10 or more percent of the overall total responses. Together they equal 80% of the responses.

Access to specialists/consultants is the first category (21%). Within this category, the top issues are quicker/better access to specialists, consults via the phone with specialists and simplified referrals.

Team work/collaborative practice follows with 15%. There are a number of issues identified including: nurse on premise (preferably funded), multidisciplinary team paid by region (in office or associated with practice), better access to mental health services, better access to other health care providers (may also include mental health), nurse practitioner in office, ability to delegate more to staff, more extensive access to home care.

Electronic records/technology is the third category (12%). Basically physicians want electronic technology in their offices, paid for and supported by the system.

Access to diagnostics comes fourth with just under 12%. The major concerns here are quicker/better access to diagnostic facilities and improved quality of and/or quicker return of lab reports.

Time issues came fifth in terms of being able to improve quality and capacity with 11%. Physicians want less paperwork and bureaucracy. Some specified more time per patient based on patient need, usually equating it to dollars, so this is closely related to the perceived need for adequate remuneration. Others specified 'more time' without specifying it to patient care.

Remuneration issues were identified almost 10% of the time. This includes: adequate remuneration in order to compensate for spending appropriate time with patients, adequate remuneration for activities such as long term care and hospital work, and payment for non face-to-face work.

The three individual codes with the highest frequency of response are quicker/better access to specialists (16%), quicker better access to diagnostic facilities (10%) and adequate remuneration (7%).

Conclusions

“Something needs to happen. Primary care services offer a great opportunity to increase capacity throughout the system with “outside the box” solutions and “new” ways of offering services – teams and networks, electronic systems, primary care specialists focusing on clinical areas to support specialist and family practice networks.”

“If these suggestions were implemented, medical practice would become more enjoyable and rewarding.”

Family Physicians

Family physicians play an essential role in the delivery of primary health care services. The provision of high quality primary health care services by family physicians 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. The FPQC Study has identified issues relating to quality and capacity from the perspective of the family physicians and will facilitate the development of potential strategies to address these issues.

The series of focus groups held in late 2000 with 46 family physicians from the Capital Health Authority identified a number of issues relating to quality and capacity in primary care family practice. These issues were used in the development of the questionnaire sent to all family physicians in the region. The questionnaire was not only trying to determine the representativeness of these issues, but also to determine the willingness of family physicians within the CHA to move forward with solutions to the issues.

The results of the questionnaire clearly indicate that **family physicians in the CHA are concerned about quality and capacity issues and that they are receptive to trying innovative means of addressing the issues.** However, the physicians indicate that innovations require system changes which cannot occur without the support and participation of stakeholders such as the CHA, Alberta Health & Wellness, the Alberta Medical Association and other health professionals. The level of interest and reflective suggestions provided by physicians in this Study confirms the need for their inclusion in the decision making processes for the development of new ways of practicing. 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 services in the Capital Health Authority will be strengthened.

APPENDIX 1 – Physician Sample for the Survey

The FPQC questionnaire was sent to all physicians considered to be providing family practice services within the CHA. The purpose of the questionnaire was 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.

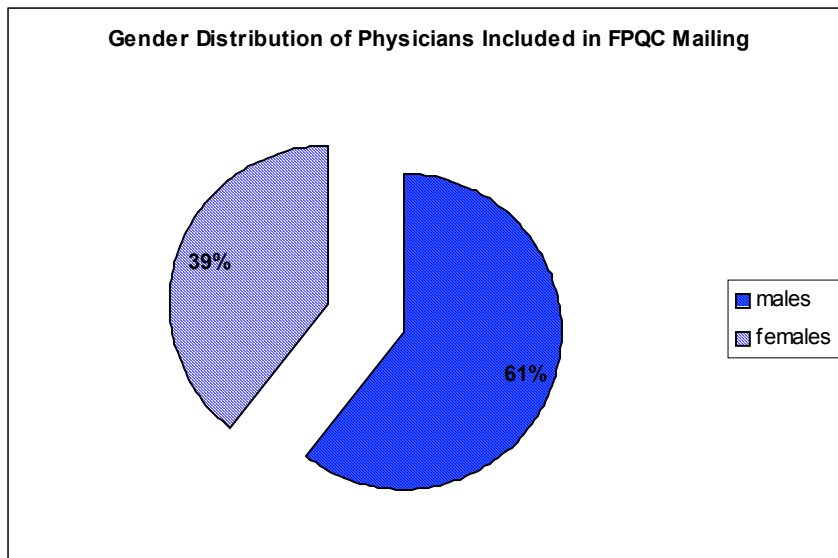
The database contained information on 821 physicians with an address within the CHA boundaries (up to three addresses per physician can be on file – primary practice address, secondary practice address and home address). Of these, 13 physicians were removed because they had not filled out the questionnaire 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.

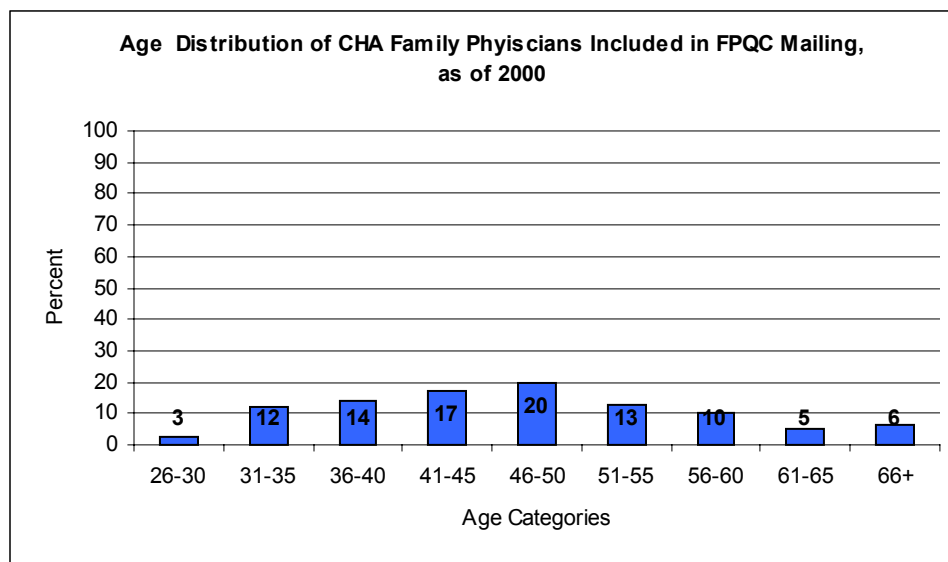
The mailing list originally obtained in April from the College of Physicians & Surgeons of Alberta was incorrect (through no fault of the College). Since the list was going to be revised, the Project Team decided to alter the assumptions slightly and include physicians who practice 'general practice' 30% or greater of their practice (rather than the previous list cut off at the 50% mark). Nine physicians, who had been erroneously included, were removed and an additional 12 were added, for a final total of 583 family physicians.

This left a total of 583 physicians delivering general practice services within the CHA. Each of these physicians was sent a copy of the FPQC questionnaire.

The following chart shows the gender distribution of the physicians.

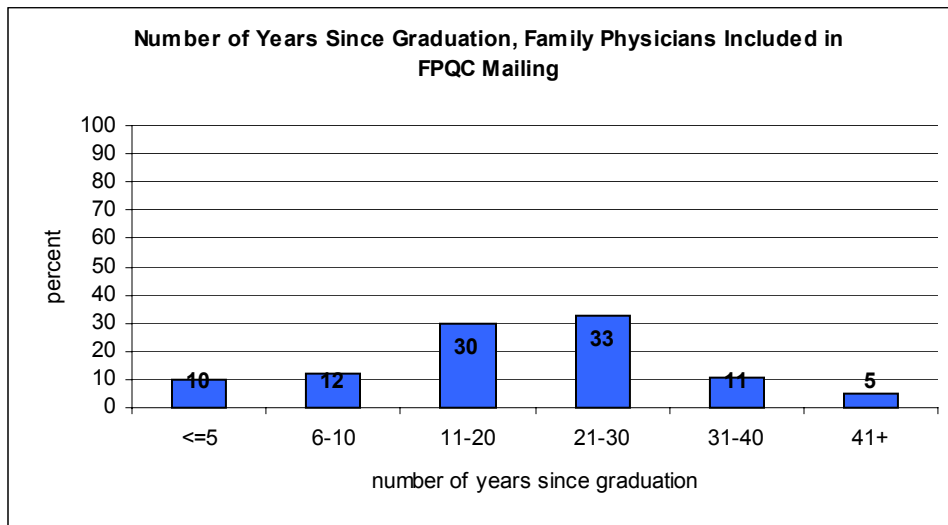
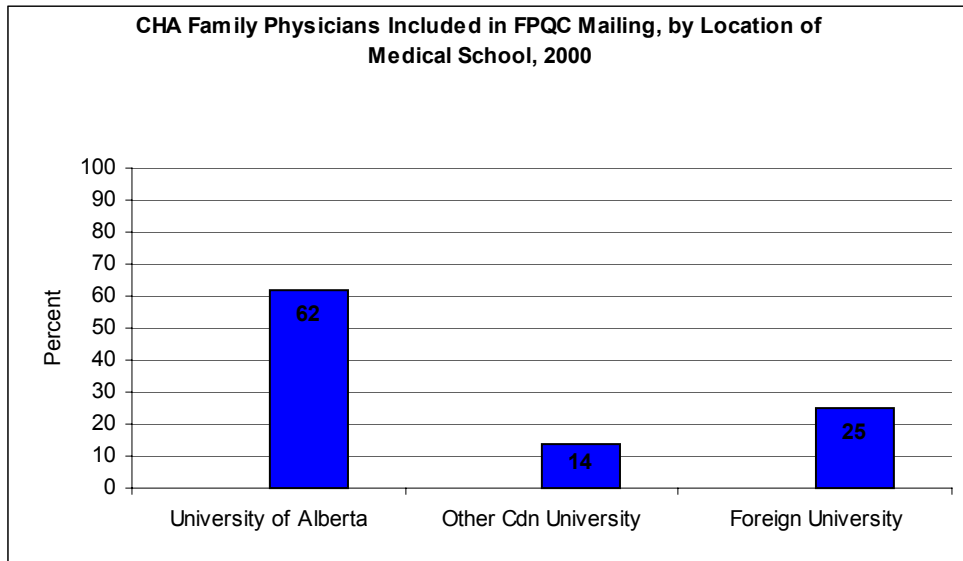


The next chart shows the age distribution of physicians practicing family medicine within CHA.

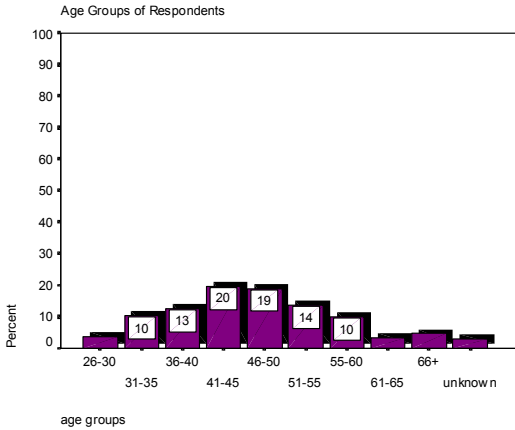
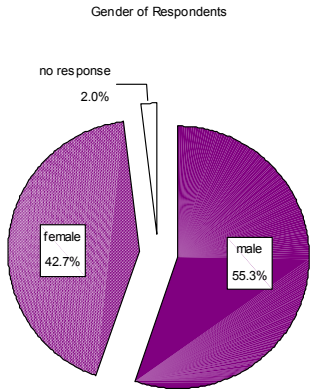


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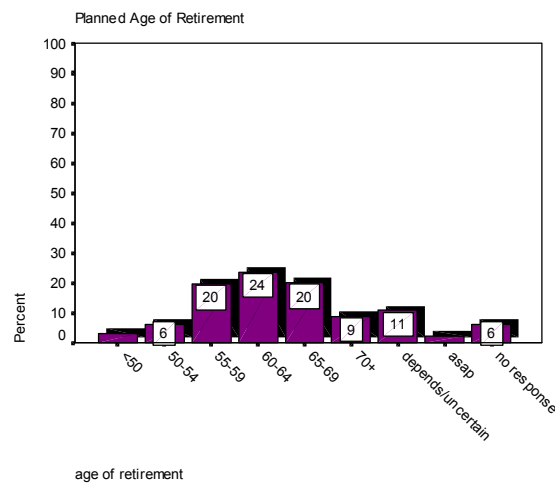
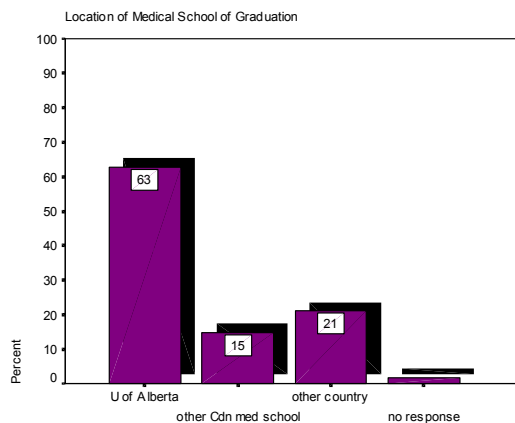
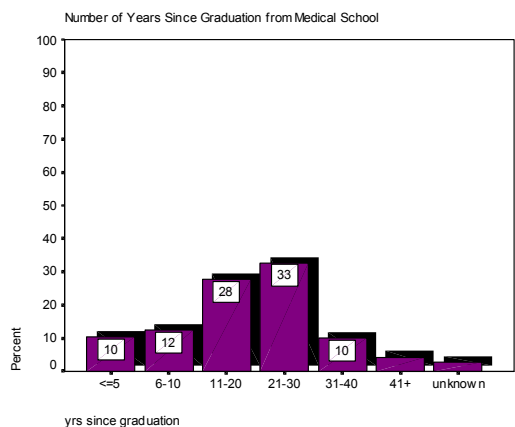
Family physicians by location of medical school and by number of years since graduation from medical school are shown in the following two tables.



APPENDIX 2 – Demographics of Responding Physicians



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