

The Wait Starts Here

The Primary Care Wait Time Partnership



FINAL REPORT

DECEMBER 2009



The College of
Family Physicians
of Canada

Le Collège des
médecins de famille
du Canada

ASSOCIATION
MÉDICALE
CANADIENNE



CANADIAN
MEDICAL
ASSOCIATION

The Primary Care Wait Time Partnership

was established in 2007 between

The College of Family Physicians of Canada

and

The Canadian Medical Association

with the purpose to explore the complex issues of primary care wait times and to put forward recommendations for timely access to primary medical care in Canada.

Contents

Executive Summary	v
Introduction	1
Methodology and Scope of Report	2
Methodology	2
Scope	2
What Does It Mean?	3
Primary Care	3
The Concept of the Medical Home	5
Primary Care Models	5
Timely Access	6
A. To Family Medicine	6
B. To Specialty Care	7
C. Rural Versus Urban Access	9
Next Steps - Finding Solutions	10
A. Measuring Primary Care Wait Times	10
B. Setting Targets	10
C. Remuneration Models	18
D. Electronic Medical Records	19
E. Practice Support	20
Recommendations	21
General Recommendations	21
Recommendations for Patients without a Family Physician	22
Recommendations for Patients who have a Family Physician	22
Recommendations for Referral from Primary to Specialty Care	23
Concluding Remarks	24
References	25

Acknowledgements

The College of Family Physicians of Canada and the Canadian Medical Association wish to thank the Primary Care Wait Time Partnership under the leadership of its co-chairs, Dr. Tom Bailey BC and Dr. Lydia Hatcher NL. Members of the partnership include Drs. Robert Boulay NB, Shireen Mansouri NT, John Tracey ON and Ruth Wilson ON. Finally, we wish to thank Dr. William Beilby of the Canadian Medical Protective Association (CMPA), Ms. Eileen Patterson of the Ontario Health Quality Council and our staff: Dr. John Maxted and Mr. Eric Mang (CFPC) and Mr. Owen Adams and Ms. Kelly Stevenson (CMA).

Executive Summary

In 2007, The College of Family Physicians of Canada (CFPC) and The Canadian Medical Association (CMA) established a partnership to explore wait times in primary medical care – the CFPC-CMA Primary Care Wait Time Partnership (PCWTP). The goal of the Partnership is to advocate for timely access to health care for all Canadians.

The first part of the wait time continuum that can be measured is when the patient schedules his or her first visit with a family physician. A family physician may then refer the patient to specialty care. Both of these stages in the continuum have not been addressed in wait time discussions thus far. The available evidence suggests that one-half of the total waiting time for family physician referral to treatment is from family physician referral to when the patient is seen by the consulting specialist.

Thus, there are three main issues around our focus on primary care wait times:

- Access to primary care for those without a family physician;
- Access to primary care for those with a family physician; and
- Referral from primary to more highly specialized care.

The CFPC has proposed a target that 95% of Canadians in each community have a family physician by 2012. There are two ways to achieve this goal: 1. increase the number of family physicians practicing in Canada and 2. increase the capacity of existing family physicians. To help address the supply issue, medical schools must find innovative ways to encourage more medical students to choose family medicine. A second approach to increasing the supply of family physicians is to provide more training opportunities so that qualified International Medical Graduates can be integrated into the family physician workforce. In terms of capacity, there are a number of approaches that have been taken to help improve family physicians' ability to take on additional patients. For example, financial incentives geared towards this objective have been included in some physician contracts. However, much more can be done in this regard, such as improving patient flow with more efficient practice management procedures

There are several models for primary care delivery operating in Canada, including various collaborative practice arrangements with different care providers working together. However, thus far there is no conclusive evidence that any one particular model is better than all of the others in terms of providing timely access to care. Many studies have compared various models in a variety of ways; each with different conclusions. While there is no definitive research on best models for primary care delivery, there is a range of innovative approaches to enhancing timely access to quality primary medical care. More research is necessary to help determine which model or models of primary care, if broadly implemented, will make considerable improvements to patient access.

Aside from collaborative care practice models, we must look for solutions that increase patient access to care through enhanced practice efficiency and not by expecting family physicians to work harder and longer. Physicians should be educated on how to run a practice from a patient flow point of view as well as a financial one. To address this, enhanced practice management training should be provided during medical school education and residency levels and Continuing Medical Education programs should be created.

One method of improving practice efficiency is through a process known as Clinical Practice Redesign (CPR). The main objective CPR is to improve patient flow through a medical practice. This involves the use of effective scheduling management techniques that allow appropriate prioritizing of patient visits. This undertaking requires commitment from physicians as well as effective information management and measurement tools, additional practice support and assistance from change management experts. These efforts can go a long way to help improve patient access and increase capacity to accommodate patient appointments.

One of the key challenges of primary care wait times is to establish guidelines for timely access to specialty care. This is potentially an enormous undertaking given that there are some 60 recognized specialties and sub-specialties in Canada and each of them is responsible for treating a number of conditions presenting to the family physician. Due to the varying degree of complexity of a patient's medical problem, an appropriate wait time would be difficult to define by a particular disease or illness.

Given the wide spectrum of illnesses that are assessed in a primary care setting, any approach to developing wait time targets must be done in consultation with family physicians and with clinical guidelines in mind.

When a patient is referred to more highly specialized care, a concerted effort must be made to keep the lines of communication as open as is feasible between family physicians and consulting specialists, in both directions. Improved communication between providers is essential to improving the wait time at this point in the continuum.

While timely access to family physicians and the referral time to other specialists is a nationwide concern, access to health care can be a greater challenge in rural locations. Any guidelines regarding wait times to specialty care must also account for the geographic factors that affect access.

When considering the concept of target-setting, a significant investment in information infrastructure is required to facilitate the measurement and monitoring of access to primary care physicians and referrals to other specialists. Furthermore, it must be acknowledged that regardless of how targets are determined, even if they are met, not everyone will receive care within the most appropriate period of time for their particular situation.

Introduction

In 2007, The College of Family Physicians of Canada (CFPC) and The Canadian Medical Association (CMA) established a partnership to explore wait times in primary medical care – the CFPC-CMA Primary Care Wait Time Partnership (PCWTP). The goal of the Partnership is to advocate for timely access to primary care for Canadians.

The Partnership released its interim report, ...*And Still Waiting: Exploring Primary Care Wait Times in Canada*, in April 2008 to stimulate discussion and agreement about ways to improve timely access to primary care and from primary to more highly specialized care. It reviewed a broad range of issues faced by family doctors in a health system that has largely ignored the wait time challenges their patients face and was very well received by members of the CMA, CFPC and other stakeholders. This final report is a focused approach to some of the recommendations and solutions, especially of relevance in primary medical care.

The difficulty in measuring primary care wait times for myriad illnesses and conditions was identified in the first report as one that may impede progress in finding solutions to the wait time challenges that family doctors experience. The PCWTP believes that the initial requirement is the ability to measure and track wait times along the continuum of the patient's care but that this capacity in primary as well as more highly specialized levels of care is still very limited. There is also the need to prioritize which benchmarks or targets should be attained along the patient's wait time continuum: 1) to find a family physician; 2) to be seen by a family physician; and 3) to have a diagnostic intervention or to be seen by a consulting specialist.

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Methodology and Scope of Report

Methodology

This paper is an opportunity to draw attention to issues of relevance to family physicians and their patients waiting for care – either to find a family doctor, or to be seen by their family doctor or to be seen by another specialist. The paper is a reflection of several data sources, including:

- Expert opinion from family physician leaders in practice and research
- The National Physician Survey (NPS) results from 2004 and 2007
- Stakeholder consultation

Given the available expertise within the PCWTP representing two national medical organizations that advocate for patients in primary care and for the resources that support high quality care, the authors of this paper are in a unique position to use their knowledge and understanding to contribute to the proposed solutions and recommendations.

Scope

It is easier to define what is in than what is out of scope for this paper. There is a variety of important influences coming to bear on primary care wait times. Some are beyond the scope of this discussion. For example, the health system is promoting more collaborative care and while this is an increasingly important part of practice, its influence on primary care wait times has yet to be determined.

There are also enablers and impediments to improved access to care, some of these still poorly defined. For example, where a physician practices and the influence of location, e.g. suburban in contrast to rural communities, makes a difference to access. The location of resources based on criteria such as cost-effectiveness and skill maintenance requires more attention. Likewise, new models of primary care are encouraging incentives to practice differently. But it is still uncertain how these new models of care are affecting access to timely care.

Finally, there are many personal factors that affect patient choice and physician decision in determining when access is acceptable or when it is intolerable. Risk plays an important part in these decisions but not all risk is measurable. Some experts have also suggested not every waiting list is a bad list. These issues require much more analysis than this paper allows.

In short, recommendations for further research will be reinforced as much by what we know as by what we still do not know.

What Does It Mean?

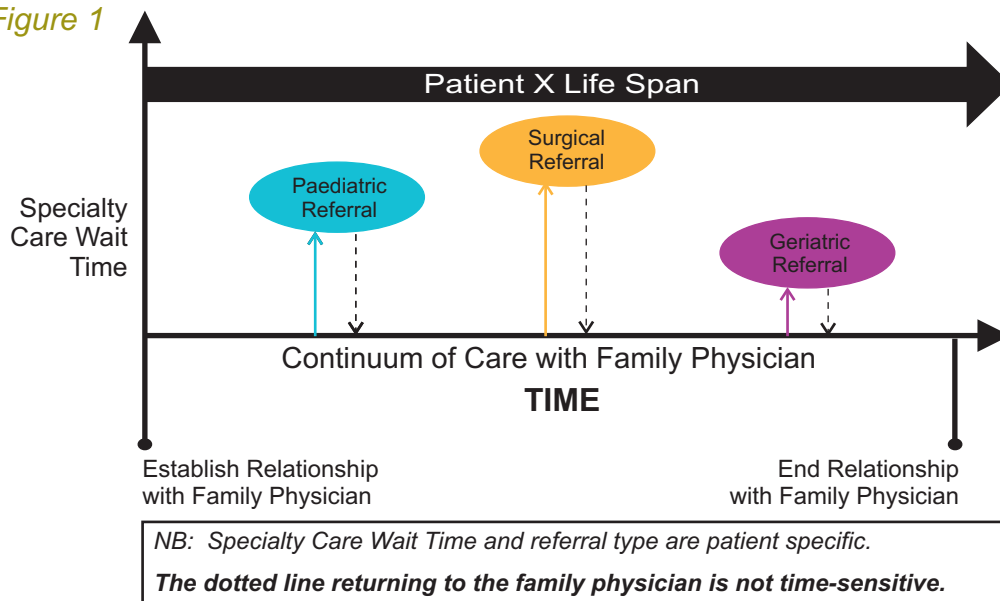
Primary Care

In the first report by the PCWTP, primary care was defined as first-contact medical care and services provided by family physicians and general practitioners. In contrast, primary health care was defined as the broader determinants of health, including health services delivered by other professional providers. Likewise, in that report it was acknowledged that “primary care is the foundation and family physicians are the backbone of the health system as the first points of contact for most patients.” Patients have access to a continuum of medical services by first presenting to their family physician at the primary care level.

Individuals may require specialty care at various points in their lives. Patients may see several specialists for a variety of problems; however, patients' family physicians play an important role during interaction with specialty care throughout the continuum of lifelong care. (Figure 1)

Patients may see several specialists for a variety of problems; however, patients' family physicians play an important role during interaction with specialty care throughout the continuum of lifelong care.

Figure 1



What does it mean to have a family physician? As set out in the CFPC's Four Principles of Family Medicine, a person may be said to have a family physician when they have established a patient-physician relationship that provides for continuing care through repeated contacts across the life cycle and in which the physician becomes an advocate for the patient by referring to other specialists and other health care resources as appropriate. While in the past this relationship has often been established through an unwritten contract, in some of the new practice models patients are formally “rostered”, that is to say they sign a commitment to seek all of their non-emergent care from the particular physician or clinic.

What does it mean to have a family physician? As set out in the CFPC's Four Principles of Family Medicine, a person may be said to have a family physician when they have established a patient-physician relationship that provides for continuing care through repeated contacts across the life cycle and in which the physician becomes an advocate for the patient by referring to other specialists and other health care resources as appropriate.

What does it mean to not have a family physician? Persons without a family physician are those without an established relationship with a primary care physician who maintains a continuous medical record for them.

The largest population-based surveys that collect data on health care use among the general population have been conducted by Statistics Canada. They have not asked specifically about “family physicians” but rather about “regular doctors” or “regular medical doctor”. In its 2007 Canadian Community Health Survey (CCHS), Statistics Canada asked the simple question, *Do you have a regular medical doctor?*¹ Nationally, 85% of the population aged 12 or older reported that they did. In 2008, the CFPC commissioned a Harris/Decima survey and found that 86% of respondents had a family physician.² The CFPC proposed a target that 95% of Canadians in each community have a family physician by 2012. Some regions of the country may be close to attaining this target while others have far to go.

Persons with a regular doctor are more likely to report greater continuity of care. According to Statistics Canada's 2007 Survey of Experiences with Primary Health Care, among the 86% of the population reported to have a regular medical doctor, 95% said that they would either definitely or probably be taken care of by the same physician or nurse each time they visited their physician's office. In contrast, among the 10% of the population with no regular doctor but some regular place of care, just 31% said they would definitely or probably see the same physician or nurse with each visit.³

What does it mean to not have a family physician? Persons without a family physician are those without an established relationship with a primary care physician who maintains a continuous medical record for them. These are referred to as unattached (or orphaned) patients. They obtain episodic care from places like walk-in clinics and hospital emergency rooms (ERs). A recent report by the Institute for Clinical Evaluative Sciences (ICES) found that there are significant excess visits to ERs among people with chronic conditions who do not have a regular family physician.⁴ Reducing the number of unattached patients could therefore have a substantial impact on the problem of overcrowded ERs.

Of the estimated 4.1 million Canadians aged 12 and over who indicated that they did not have a regular doctor in the 2007 CCHS, 78% reported that they had some other usual source of care. Among these individuals, the most frequently cited source of care was walk-in clinics (64%), followed by hospital emergency rooms (12%), community health centres (10%) and “other” (14%).⁵

The Concept of the Medical Home

For those with a family physician there has been an increase in the literature in the United States on the concept of a “medical home”. In 2007 the American Academy of Family Physicians and three other medical associations adopted “joint principles of the patient-centered medical home” that include:

- each patient having a personal physician
- physician directed medical practice
- whole person orientation
- coordinated care across all elements of the health system
- quality and safety (e.g. support for optimal patient-centered outcomes)
- enhanced access to care (e.g. open appointment scheduling); and
- appropriate payment incentives.⁶

The Commonwealth Fund attempted to assess the proportion of patients with a medical home in their 2007 International Health Policy Survey. Their definition included patients that have “a regular doctor or place that is very/somewhat easy to contact by phone, always/often knows medical history, and always/often helps coordinate care (yes).” While 84% of Canadian respondents on the survey reported that they had a doctor that they usually see (consistent with all other survey estimates), just under one out of two (48%) were considered to have a medical home according to the Commonwealth Fund definition. Of the seven countries surveyed, respondents in New Zealand and Australia were the most likely to be considered as having a medical home (61% and 59% respectively).⁷

Primary Care Models

There are several models for primary care delivery and thus far there is no conclusive evidence that any one particular model is better than all of the others. Many studies have compared various models in a variety of ways; each with different conclusions. For example, a comprehensive comparative study on the productive efficiencies of four models of primary care delivery in Ontario concluded that no one type of model dominates and that further research is required.⁸

Furthermore, another study comparing various primary health care models with regard to a number of variables including access and quality came to the same conclusion. It found that the fee-for-service physician practice model ranked highest in terms of patient access and responsiveness, while community health centres ranked highest in effectiveness, productivity, continuity and quality.⁹

Finally, another study that compared patient satisfaction in walk-in clinics, ERs and family practices came to the conclusion that in terms of waiting time, patients were most satisfied with family practices.¹⁰

While there is no definitive research on best models for primary care delivery, this report shows there is a range of innovative approaches to enhancing timely access to quality primary medical care.

Timely Access

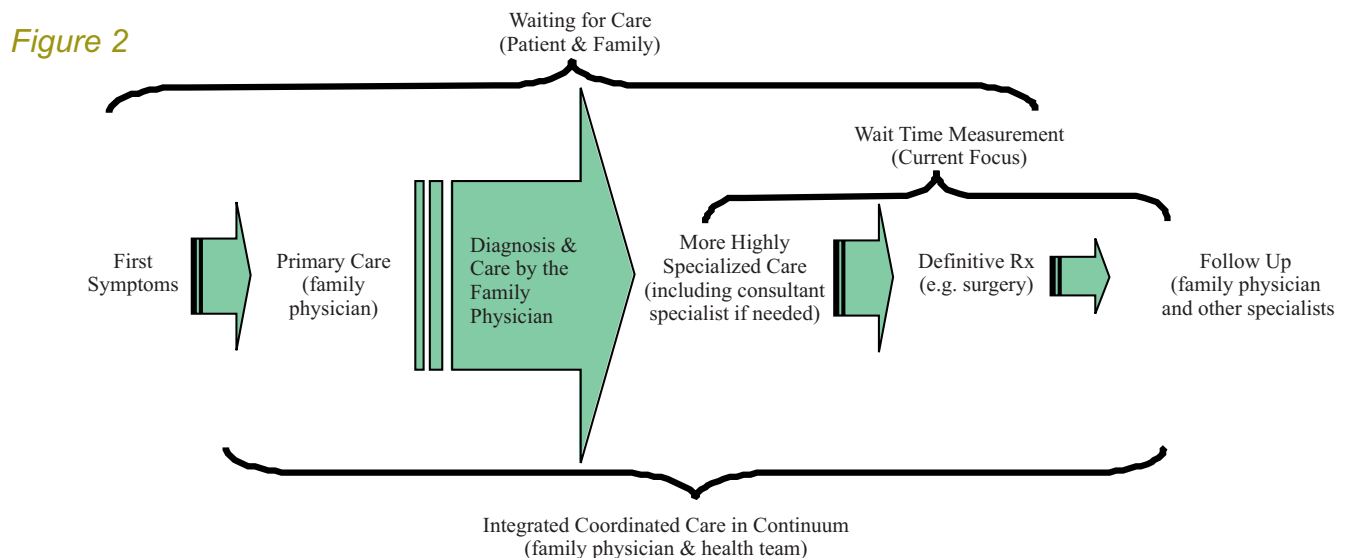
The issue of wait times has dominated the health policy agenda in Canada, particularly since the First Ministers Accord in 2004. Prior to that however, in their February 2003 Accord, which they considered to be a “covenant”, governments agreed to develop and report on common indicators. Among the 40 indicators listed in the 2003 Accord, in addition to access to primary care (measured as a percentage of the population with a regular family doctor and a percentage of doctors accepting new patients), the list included seven wait-time/volume indicators, of which the following were pertinent to primary care:

- referral to specialists for cancers (lung, prostate, breast, colo-rectal), heart and stroke;
- diagnostic tests (MRI, CT); and
- proportion of services/facilities linked to a centralized (provincial/regional) wait list management system for selected cancers and surgeries, referral to specialists, emergency rooms and diagnostic tests.¹¹

These commitments were overtaken, however, by the 2004 Accord which called for evidence-based benchmarks for five procedures including cancer, heart, diagnostic imaging, joint replacements and sight restoration.¹² National benchmarks were achieved in December 2005, but they begin from the point where the decision has been reached on treatment between the consulting specialist and patient.¹³

A. To Family Medicine

In discussions regarding the total time patients wait for care, what is often overlooked is the fact that the wait time continuum starts when a patient has a medical problem. However, the first part of the continuum that can be measured is when the patient schedules his or her first visit with a family physician. Figure 2 below illustrates the full wait time continuum.



Source: The College of Family Physicians of Canada, September 2006

Access to a family physician is a major concern in this country. In a series of focus groups conducted by Ipsos-Reid across Canada in 2007 on behalf of the CMA, the following concerns/issues were raised by some patients:

- people had been searching for a family physician for several years without success;
- people with a family physician were frightened about the prospect of their doctor retiring; and
- people with a family physician reporting waits of three or four weeks to get an appointment.¹⁴

According to the Commonwealth Fund survey in 2007, Canada had the lowest rate of same-day physician appointments by a wide margin. 22% of respondents said they could see their physician on the same day, versus 30% in the US and 41% and higher for the remaining five countries. Canada also had the highest rate of respondents noting it took six or more days to see their physician, at 30%, as opposed to 20% for Germany and the US and lower for the other four countries surveyed⁷. However, in the 2007 National Physician Survey (NPS), 65% of family physicians stated that their patients with urgent needs are able to see them within one day. For non-urgent cases, 41% are able to see their patients within one week and 66% are able to see their non-urgent patients within four weeks.¹⁵

In the 2007 Health Council of Canada survey, of the 26% of respondents who stated they require routine or ongoing care, 45% noted that they had to wait too long for an appointment and 29% said it was difficult to get an appointment.¹⁶ Furthermore, according to the 2007 NPS, when other specialists were asked to rate their patients' access to family physicians, only 13% gave it a very good or excellent rating, while over half (55%) gave it a fair or poor rating.

This survey also found that 86% of family physicians stated they had made arrangements for care for their patients outside of their normal office hours. When asked to list the arrangements they have in place, one third (33%) said they extend their office hours, over one third (37%) operate an after-hours clinic that is staffed by members of their practice and 41% included calling a 24/7 telehealth phone line as an option. However, over half (52%) included going to an ER as one of these arrangements.¹⁵

The aforementioned surveys have shown there is evidence of a disparity between patients' and physicians' perspectives regarding access to primary care. Moreover, Canada lags behind other countries in access to primary care.

B. To Specialty Care

The next stage of the wait time continuum is also often overlooked. This is when a family physician refers the patient to specialty care. The Fraser Institute's research on patient wait times does take this into account, however. According to their most recent survey, the average wait time between referral by a family physician and a consulting specialist fell from 9.2 weeks in 2007 to 8.5 weeks in 2008.¹⁷ It is encouraging to see some movement in the right direction, but there is much more room for improvement. According to the 2007 NPS, only one quarter (24%) of family physicians rated patient access to other specialists as very good or excellent, while over one third (36%) of family physicians rated patient access to other specialists as fair or poor.¹⁵ Some specialists will not take phone calls from family physicians – the only method of communication is by fax, which makes it difficult for the family physician to confirm whether the consulting specialist has received the referral and acted on it.

Efforts must be made to keep the lines of both communication and access as open as is feasible between family physicians and consulting specialists, in both directions. Other specialists have noted having some difficulty scheduling appointments for their patients with their family physicians after consultation and/or treatment.

The CMPA has identified a specific process for referring physicians to follow and includes the following guidance: When a patient is referred to a consulting specialist, the family physician should provide sufficient clinical information so that the consultant can appropriately prioritize his or her referrals.

The Canadian Medical Protective Association (CMPA) has identified a specific process for referring physicians to follow and includes the following guidance: When a patient is referred to a consulting specialist, the family physician should provide sufficient clinical information so that the consultant can appropriately prioritize his or her referrals. The consultant should notify the family physician of the patient's scheduled appointment. If the timing of this appointment does not seem reasonable to the family physician, he or she should then attempt to schedule an earlier appointment. If this is not possible, the family physician should consider alternative options to seek specialty care and discuss these with the patient. The patient should also be informed of what to expect if his or her condition changes while waiting for specialty care, and what to do and who to consult if this occurs.¹⁸ The Collaborative Action Committee on Intra-professionalism (CACI) was established in 2006 by the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada to discuss enhancing intra-professionalism and exploring ways to encourage desired behaviours that will improve physicians' intra-professional relationships. This work is vital to ensure a seamless continuum of care for patients between family physicians and other specialists. Working groups have been established to focus on improving relations through medical education, training and accreditation and in practice by developing enhancements to the referral–consultation process.¹⁹

Should a timely referral not be available, the CMPA's latest guidance on wait times in a September 2007 information sheet addresses the issue of liability when health-care resources such as specialty care are limited. The sheet notes that physicians may be requested to provide care outside their area of expertise when resources are scarce. While noting that the courts have yet to address this issue, it suggests the “courts will not evaluate your decisions against a standard of perfection. Rather, your decisions will be evaluated in light of what a reasonable and prudent physician like you would have decided in similar circumstances”.²⁰ Nonetheless, given that the decision to refer implies that a physician has determined that a problem is beyond his or her scope of practice, the issue of support for the physician managing what might be long waits for specialty care will need to be addressed.

An additional barrier to timely patient access to specialty care is the inconsistency in family physicians' abilities to order advanced diagnostic tests. The Canadian Association of Radiologists (CAR) has guidelines for all physicians to follow when ordering diagnostic tests.

Nevertheless, some family physicians are not permitted to order these advanced tests. These rules are set at the regional health authority (RHA) or hospital level in most jurisdictions. There are at least three major consequences to a family physician's inability to order advanced diagnostic tests:

- a patient's wait time for total care is delayed because tests must be ordered after what may be a prolonged wait to get into specialty care;
- the consulting physician's time is used inefficiently because she must order the tests and call the patient back and/or reschedule an appointment; and
- the health care system is overburdened because the diagnostic test may provide information to the family physician that would negate the need for additional referral to specialty care.

C. Rural Versus Urban Access

While timely access to family physicians and the referral time to other specialists is a nationwide concern, access to health care is often considered a greater challenge in rural locations. The 2007 NPS survey found that this is not the case. In fact, the opposite is true. There is very little difference in same-day family physician access rates between urban and rural locations and with regard to other specialties, the difference between urban and rural physicians is notable, with 51% of rural physicians stating that urgent appointments can be made on the same day as opposed to only 37% of urban physicians.

However, there is a difference between rural and urban settings with regard to factors that increase demand on a physician's time. For example, the 2007 NPS found a lack of availability of other specialists locally was a more significant factor for rural physicians (65%) than for urban (55%), as was the lack of other health care professionals, which was a concern for 66% of rural physicians in contrast to 54% for urban physicians. This survey shows that health human resources is a concern for all physicians, especially in rural settings.¹⁵

It should be pointed out that rural and urban physicians' differing perceptions about access for their patients may have an effect on survey findings; the weather and distance to travel to obtain specialty care, for example, affect a rural family physician's view of the quality of access.

The 2007 NPS found that access to Routine and Advanced Diagnostics was rated very similarly by rural and urban physicians of all specialties, with access to routine services rated higher than access to advanced services in all respects. When the physician's specialty is taken into account, both rural and urban family physicians rated access to routine diagnostics higher than other specialists (very good or excellent – 48% versus 37%). The reverse is true for access to advanced diagnostics, with 15% of family physicians rating it very good or excellent, whereas 21% of other specialists gave it these rankings.¹⁵

Any guidelines regarding wait times to specialty care must also account for the geographic factors that affect access. The most commonly regarded solution to the problem of access to specialty care in rural regions is to increase the number of specialty services in that area; for many specialties, however, this may not be feasible due to insufficient numbers of patients residing in the area to support an effective workload.

Next Steps - Finding Solutions

A. Measuring Primary Care Wait Times

What primary care wait times should be measured? How can they be measured? While the selection of the five priority areas noted earlier has stimulated progress in the measurement of waiting for treatment once the consulting specialist has been seen, as the Fraser Institute has reported for the past two years, nationally one-half of the total waiting time for family physician referral to treatment is from family physician referral to when the patient is seen by the consulting specialist. In 2008 the Institute estimated the average total wait from referral to treatment at 17.3 weeks; of this the wait from referral to specialty consultation was estimated at 8.5 weeks – 49% of the total¹⁷.

For the purposes of this paper, “target” is defined as a time-based standard for accessing care.

Among the recent provincial/territorial initiatives there has been no systematic effort to capture the time from family physician referral to specialty consultation. For its part, the Wait Time Alliance is launching a project in spring 2009 that will record the actual total waiting time from initial referral to treatment among a sample of consulting specialists and their patients.

B. Setting Targets

For the purposes of this paper, “target” is defined as a time-based standard for accessing care. This may be further graduated by the urgency for which the care is needed, and it may also be qualified by a percentage threshold of attainment. For example, “90% of patients with the least urgent requirement for care will be seen within one month of referral”.

When considering the concept of target-setting, two important points must be stressed:

- before any reasonable wait time targets can be established, a significant investment in information infrastructure is required to facilitate the measurement and monitoring of access to primary care physicians, appointments and referral to other specialists; and
- regardless of how the targets are determined, even if the targets are met, not everyone will receive care within the most appropriate period of time for their particular situation.

Targets to Accessing Primary Care

There are two key considerations in this paper with regard to targeting wait times in access to primary care. While other jurisdictions and researchers have considered other approaches, e.g. wait times to access a primary care setting, this paper is focused on ways to improve timely access to primary medical care for those Canadians who have their own family physician and for those who do not – as well as timely access to specialty care services from their family physician.

Finding a Family Physician

What would it take to reach the target of 95% of Canadians in each community having a family physician by 2012? An estimated 4.1 million Canadians aged 12 or older do not have a family physician. Statistics Canada further subdivides the 4.1 million into those who have not looked for a family physician (2.4 million) and those who have looked but cannot find one (1.7 million).¹ A telephone survey conducted by Harris/Decima in October and November 2008 found that of the 14% of respondents who do not have a family physician, 61% were not looking for a family physician for themselves or a family member. 45% of these stated they are not looking for one because they go to a walk-in clinic or an ER instead, whereas the other half were not looking because they presumed no family physicians were available.²

It would seem reasonable that the population who has looked for but cannot find a family physician should be a priority target to advancing toward the 2012 goal. As advocated and explored by the CFPC, this may entail establishing registries for unattached patients in communities across Canada. Several provinces and territories have included incentives in their physician contracts for taking on unattached patients and it would be useful to assess their effectiveness.

One way to increase the number of family physicians practicing in Canada is to encourage more medical students to choose family medicine by exposing them to family practices early on and to obtain placements in practices that are keenly interested in demonstrating the benefits of family practice to medical students. Support for family practice preceptors and teachers is also important. Incentives to attract more preceptors are required and facilities should be created to improve medical students' awareness of these opportunities across the country.

Ontario has set a target of finding a family physician for 500,000 unattached patients over the next three years.²¹ Ontario already has in place an incentive schedule for patients in its primary care models to take on new patients. The most common of these models (i.e. with the largest number of physicians participating) is the Family Health Group, which provides a payment of \$100 each for up to 50 newly enrolled patients without a family physician per year with a premium of 10% for patients aged 65-74 and 20% for those aged 75 and over. There is also a payment of \$150 for rostering unattached patients discharged from an inpatient hospital stay. Effective April 1, 2009 a complex/vulnerable new patient fee of \$350 will also be introduced, with criteria still under development.

New Brunswick has a pilot project in place that is based on a \$150 premium, payable in addition to fee-for-service (FFS) billings in installments of \$50 per visit up to the maximum. In the Yukon, family physicians who accept unattached patients are paid \$200 over and above the initial visit fee.

95% of Canadians in each community should have their own family physician by 2012

Another option currently being discussed in a number of jurisdictions is to allow faster integration of qualified International Medical Graduates (IMGs) by evaluating the equivalency of family medicine training and qualification programs done in other countries. In order to increase the number of family physicians who are trained to provide high-quality care, the CFPC recently approved the following initiatives:

- Expansion of the Alternative Route to Certification for practicing FPs interested in Certification in Family Medicine (practice eligible) to those who have been practicing for at least five years in Canada.
- Granting Certification to family physicians who hold Certification with the American Board of Family Medicine (ABFM), are in good standing with the American Academy of Family Physicians and are moving to Canada.
- Evaluate other postgraduate family medicine training and certification programs in jurisdictions outside Canada in order to consider granting reciprocity for family physicians with training and certification equivalent to family medicine programs in Canada.

Access to Family Physicians

In terms of targeting approaches to the time to get an appointment to see the family physician, it would appear that the “evidence-based” approaches of urgency scoring will be impractical because they require an assessment of the patient. It may be worth investigating the methodology used by the provincial health phone lines to triage patients based on the use of structured algorithms and exploring whether this can be used in a primary care physician office to better gauge the level of each patient's need to see their physician and to organize the physician's patient schedule in a more effective manner. This would require additional resources (both staff and technology) be made available to the family physician's practice.

Want to learn more?

Capital Health in Halifax is exploring “a program of supports for family physicians and family practice nurses working in fee-for-service practices in Nova Scotia: www.cfpc.ca/nursinginfamilypracticeTQVI

When considering approaches to address the issue of increasing access for patients with a family physician, we must look for solutions that do so through enhanced practice efficiency and not by expecting family physicians to work longer.

Improving practice efficiencies can be accomplished through enhanced practice management training during medical school education and residency levels. Continuing Medical Education programs on this topic will also be beneficial. Physicians should be educated on how to run a practice from a patient flow point of view as well as a financial one. To encourage interest in this aspect of running a medical practice it is important that they are made aware of all of the benefits of a well-managed office (e.g. more time spent doing direct patient care, the ability to increase patient load and attain a better work-life balance).

New Approaches to Practice Management

Some progress is being made to enhance Canadians' access to primary care. A variety of projects are underway that have already shown improvements in this area, including a number of successful efforts occurring in British Columbia, Alberta and Saskatchewan that include the implementation of an innovative practice management system known as Advanced Access. The term Clinical Practice Redesign (CPR) is becoming a more popular description of the process involved.

“Advanced Access is about reengineering clinic practices so that patients can see a physician or other primary care practitioner at a time and date that is convenient for them. The advanced access model is often considered to be another scheduling system; however, it is in fact a comprehensive approach to effective patient care delivery.”²²

The main objective of CPR is to improve patient flow through a medical practice. This involves the use of effective scheduling management techniques that allow appropriate prioritizing of patient visits. The main premise is that if patient demand for appointments is overall in balance with the physician capacity to schedule appointments, it should be possible to offer patients an appointment on the same day that they telephone for one. The challenge is to work down the backlog and achieve that balance. Once this is accomplished, the wait time to see the physician can be dramatically reduced.

The originators of this concept have identified six steps in implementing CPR:

1. Measure and balance supply and demand
2. Eliminate the accumulated backlog
3. Reduce the number of appointment types
4. Develop contingency plans (e.g., flu season)
5. Reduce and shape demand (e.g., phone and e-mail for answering questions)
6. Increase effective supply by delegating tasks²³

Want to learn more?

Family Physician Dr. Ernst Schuster presents advanced access in family practices through the Alberta Access Improvement Measures (AIM): www.cfpc.ca/advancedaccessTQVI

The sentinel indicator that is used to monitor CPR is what is termed “third next available appointment” and is defined as the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment.

Another common patient scheduling technique, often misinterpreted as Advanced Access, is more accurately referred to as the “carve out” model. It involves keeping a block of time open each day for patients who call that day for an urgent appointment. While it allows patients with an urgent problem to see their family physician the same day, it could potentially make the wait time for non-urgent problems longer as there are fewer appointment times that can be used for those cases. It is nonetheless a step in the right direction and shows that family physicians are making efforts to alleviate the primary care access problem.

CPR is gaining momentum as a popular method of improving practice efficiency. The first group practice to adopt this system in Saskatchewan was able to reduce its average wait time from 17 days to just two.²⁴ In addition to reducing wait times, many practices in British Columbia, Alberta and Saskatchewan have been able to increase their patient load due to efficiency improvements. This is therefore also addressing the concern about the large number of Canadians who do not have a family physician.

The United Kingdom Experience

The UK has adopted fixed targets for primary care, irrespective of the patient's presenting condition. The 2004 National Health Service (NHS) Improvement Plan set out a 24/48 hour access target, by which UK patients would be guaranteed the opportunity of seeing a primary care provider within 24 hours and a GP within 48 hours.²⁵ The UK has since adopted an incentive approach to achieving this target through an Improved Access Scheme. First implemented on a voluntary basis in 2007, some 5 million surveys were sent to GPs' patients across England about their recent experience with access to their GP. The survey results are linked to a reward payment that has four elements:

- 48 hour target reward element;
- advance booking target reward element;
- ease of telephone access target reward element; and
- preferred health care professional target reward element.

The level of payment for each element is linked to the satisfaction level reported by the patients.²⁶

The survey has now been successfully administered twice. In 2008, almost two million responses were received – a 41% response rate. Key findings from the 2008 survey include the following:

- 87% of patients reported that they were satisfied with their ability to get through to their doctor's surgery on the phone.
- 87% of patients who tried to get a quick appointment with a GP said they were able to do so within 48 hours.
- 77% of patients who wanted to book ahead for an appointment with a doctor reported that they were able to do so.
- 88% of patients who wanted an appointment with a particular doctor at their GP surgery reported that they could do this.²⁷

Any kind of patient-based reporting on access requires an up-to-date electronic roster of patients. The survey tool used in the UK is very simple and can be completed online. It should be noted however that the cost of the 2007 survey was estimated at £11 million although this also includes the patient choice survey.²⁸

No doubt less complex approaches could be developed for applying an incentive approach to reach targets in Canada. However, this would involve the types of supports and resources available to general practitioners in the UK. In addition, the views of the public and patients should be sought before adopting any targeting approaches in primary care. This was emphasized by Berta et al in a Canadian public opinion study of the importance of ten measures of primary care performance. They found that the most important factors for patients were related to the family physicians' knowledge and skills, while the access indicators were least important.²⁹

Targets to Accessing Specialty Care

One of the key challenges of primary care wait times is to establish guidelines for timely access to specialty care. This is potentially an enormous challenge given that there are some 60 recognized specialties and sub-specialties in Canada and each of them is responsible for treating a number of conditions presenting to the family physician. Due to the varying degree of complexity of a patient's medical problem, an appropriate wait time would be difficult to define by a particular disease or illness. National and international experience would suggest that there have been two broad approaches:

- the development of “condition-specific” approaches to target-setting linked to a clinical assessment of urgency; and
- the adoption of targets that apply to all conditions that are progressively shortened as they are achieved.

Since the early 1990s, the NHS has made remarkable progress in tackling wait times through the adoption of targets that have been gradually shortened. This began with the first UK patient charter that was adopted in 1991. Reflecting the long waiting lists at that time, it included the right, “to be guaranteed admission for treatment by a specific date within two years”.³⁰ In 1995 a second version of the Patient Charter lowered this period to 18 months, and to one year for coronary artery bypass grafts.³¹ In the late 1990s the NHS moved from the Charter to a series of national service frameworks for conditions such as heart disease and cancer. These frameworks evolved into shortened targets. For example in 2001 the target was a maximum one month wait from diagnosis to first treatment for breast cancer by the end of 2001, in 2005 this was extended to all cancers by December 2005.³² The most recent development has been the 2004 commitment that by the end of 2008 no patient will have to wait longer than 18 weeks from GP referral to hospital treatment.³³ The UK is on track to meet this target, but it must be emphasized that this has been achieved through a combination of a large infusion of resources, plus policy changes such as the shift from block funding to Payment by Results that reimburses hospitals on the basis of the number of patients treated. It should also be emphasized that the NHS is a much more integrated system than Canada's health care system, and it would be more challenging to define accountability for reaching wait time targets.

Past Work on Improving Specialty Care Access

In Canada, the “gold standard” of target-setting is considered to be the work done by Naylor and colleagues in developing the urgency rankings for coronary revascularization procedures that underpin the Cardiac Care Network (CCN) of Ontario. This was done using a modified version of the techniques developed by the RAND Corporation in the 1980s to establish appropriateness guidelines for various procedures. In this work a panel of cardiologists and cardiac surgeons rated 438 fictitious case-histories on a seven-point scale of maximum acceptable waiting time for surgery. A regression model was then used to derive a scoring system based on the regression coefficients attached to the major determinants of urgency.³⁴ This system was implemented to prioritize waitlists by CCN which now works with 18 cardiac care centres in Ontario.

A group urology practice in Saskatchewan has initiated a process whereby referring family physicians are provided with a standard form listing the necessary tests.

The Diagnostic Imaging Program Standards Committee of the Winnipeg Regional Health Authority in Manitoba found that when physicians requesting a diagnostic test provided a time frame for the test to be completed as well as information about the patient's condition, the process of prioritizing requests became more manageable for radiologists.

In Alberta and British Columbia, some family physicians have signed service agreements with other specialists. Such an agreement defines the scope of the work of family physicians and other specialists. It formally encourages all specialties to work collaboratively and to this end regular meetings are held to discuss all relevant matters.

Manitoba has recently launched a pilot project called Bridging Generalist and Specialist Care – The Right Door, The First Time that will focus on reducing the wait time between family physician referral and specialty consultation.

In the late 1990s a similar approach was used by the Western Canada Waiting List (WCWL) Project to develop priority scoring tools for cataract surgery, general surgery, hip and knee replacement, MRIs and children's mental health.³⁵ The tool for hip and knee replacement has been adapted for use by family physicians to determine priority of referral to orthopaedic surgeons, although to date it has only been tested on simulated paper cases.³⁶ The Saskatchewan Surgical network has applied the WCWL approach to develop scoring tools in 12 procedural areas.³⁷ Clearly it would be a large undertaking to adopt all these tools for use in primary care and to develop tools for the numerous areas that have yet to be tackled. Thus far, governments have concentrated, for the most part, on their initial five priorities. In the Fall of 2007 the Wait Time Alliance added five new benchmark areas, including emergency care, psychiatric care, plastic surgery, gastroenterology and anesthesiology (pain management) and it has challenged governments to adopt them.³⁸

Recent Efforts to Improve Specialty Care Access

How can we work to achieve these targets? There are a variety of initiatives underway to expedite the referral and consultation process. In 2006, the CFPC and the Royal College of Physicians and Surgeons of Canada said that three steps could improve the referral and consultation process:

- “ a defined single access point within local referral/consultation systems;
- templates for referrals and consultation advice;
 - an agreement among key players (relevant GP/FP and other specialty organizations) on referral/consultation criteria.”³⁹

As an example, a group urology practice in Saskatchewan has initiated a process whereby referring family physicians are provided with a standard form listing the necessary tests. This process has been very successful in reducing the need for repeat appointments. This practice also implemented a policy that the patient is referred to the first available urologist rather than to a specific physician. This new pooled referral system has reduced patient wait times remarkably and has been very well received by all parties.⁴⁰ In addition, other specialties in that province have shown interest in introducing a similar system in their practices.

As an additional example of simple ways to gain efficiencies, the Diagnostic Imaging Program Standards Committee of the Winnipeg Regional Health Authority in Manitoba found that when physicians requesting a diagnostic test provided a time frame for the test to be completed as well as information about the patient's condition, the process of prioritizing requests became more manageable for radiologists.⁴¹

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Manitoba has recently launched a pilot project called *Bridging Generalist and Specialist Care (BGSC) – The Right Door, The First Time* that will focus on reducing the wait time between family physician referral and specialty consultation.

This pilot project is intended to address priority areas, including:

- mental health: anxiety and depression
- lower back pain management
- lower gi endoscopy
- orthopaedics: arthroplasty
- plastic surgery: carpal tunnel, breast reconstruction, breast reduction and skin lesions
- lung cancer⁴²

One of the objectives of this pilot project is to establish guaranteed time frames from referral to consulting specialist in the specific practice areas and to offer alternative options to patients who may exceed these time lines. The BGSC software includes primary care pathways and an electronic referral process, allowing family physicians to send all necessary referral information, such as primary care workups, treatments and testing results, to the other specialist offices electronically. These specialists can then respond to the referrals electronically, advising family physician offices of referral acceptance, appointment dates and times and any additional information within days of receiving the referral request.

Want to learn more?

Ms. Brie DeMone offers an overview of the government of Manitoba's project to improve communication and coordination between family physicians and other specialists. "Bridging General and Specialist Care" and "the Catalogue of Specialized Services". www.cfpc.ca/BGSCTQVI

In January 2009, the web-based Catalogue of Specialized Services (CSS) was launched, which, is, according to provincial director of patient access Dr. Luis Oppenheimer, "like a catalogue order entry system. If you're a GP/FP looking for a service, you will get a catalogue of who provides that service, [...] some idea of the waiting time or capacity for that service [...] and have immediate confirmation of whether [your request] is accepted." By clearly providing family physicians and their offices with information on "who does what", referrals can be accurately directed to the right specialist at the right time, saving time and effort for the family physician, other specialist and patient.^{42,43}

A third new initiative currently underway in Manitoba, the Patient Access Registry Tool (PART), will provide other specialists with the clinical information they need to manage patient demand. Patient demographics and provider information as well as a diagnosis and planned interventions will be available through this tool and it will also document several key wait time dates, including when a referral was first received, the date of the first specialist consultation and when a patient is ready for treatment. Once it is fully operational, PART will capture information on all patients needing a medical consultation or surgery in Manitoba.⁴⁴

British Columbia offers a Full Service Family Practice Program with a broad range of incentives

The Nova Scotia agreement includes new Chronic Disease Management Incentives that will be linked to guideline-based care for chronic diseases such as diabetes, chronic heart failure and hypertension

Given the wide spectrum of illnesses that are assessed in a primary care setting, any approach to developing wait time targets must be done in consultation with family physicians and with clinical guidelines in mind. Currently there is simply not enough information available to establish reasonable wait time targets. The ability to accurately measure and monitor access at all points along the care continuum will require a significant investment in information infrastructure and this system must be in place and used effectively before targets are developed. More importantly, this cannot be effectively implemented without coordinated support from all governments. The Manitoba Government is a pioneer with this particular effort and their pilot projects will be closely monitored for effectiveness.

C. Remuneration Models

Since the early 1990s there has been a steadily declining trend in fee-for-service (FFS) as the sole mode of payment for family physicians. In 1990, the CMA's Physician Resource Questionnaire (PRQ) survey results showed that 71% of family physicians received 90% or more of their professional income from FFS.⁴⁵ Subsequent PRQ surveys showed successive decreases and on the 2007 NPS, fewer than one out of two (48%) family physicians reported receiving 90% or more of their income from FFS.¹⁵ While the majority of physicians continue to receive some income from FFS, increasingly it is being blended with other remuneration methods.

A blended payment model known as the Family Health Network is now available in Ontario. In this model, capitation accounts for about 65% of a family physician's remuneration. The remainder consists of fee-for-service and other incentive payments and premiums.

Over the past decade there has been an international trend towards the adoption of "pay-for-performance" (P4P), in which a variety of payment incentives are used to promote certain physician behaviours. To date, these incentives have been used mainly to encourage process improvements in the delivery of care. The earliest forms of P4P focused on prevention screening, but more recently they have expanded to address chronic disease management. P4P generally works by linking a bonus payment to the achievement of a specific performance target in the patient population. In its new primary care models, Ontario provides bonus payments for cancer prevention screening and diabetes management, as well as other incentives for activities including palliative care and care for patients with serious mental illness.⁴⁶

Similarly, British Columbia offers a Full Service Family Practice Program with a broad range of incentives.⁴⁷ The recently concluded Nova Scotia agreement includes new Chronic Disease Management Incentives that will be linked to guideline-based care for chronic diseases such as diabetes, chronic heart failure and hypertension.⁴⁸

As previously noted, several jurisdictions also provide incentives to acquire new patients. Internationally the UK has gone further by providing a bonus to the attainment of timely access targets as reported by patients. However, the UK also has a long-established rostering system and it has a much less geographically dispersed population than does Canada. Nonetheless it might be interesting to assess the potential for incentives to enhance access to primary and specialty care in Canada.

D. Electronic Medical Records

Regardless of how a wait time management strategy might be implemented (e.g., at the level of the province, health region, hospital) it will be critical to be able to capture and monitor referral data electronically, starting with the family physician. It may be seen in Table 1 below that according to the 2007 National Physician Survey, there remains a large gap in this regard. Nationally almost two out of three family physicians (63%) continue to use paper charts as their method of record keeping. One out of five (19%) uses a combination of electronic and paper charts while just over one out of 10 (12%) report using electronic charts instead of paper charts. Across the country there is more than two-fold variation of those using paper charts ranging from a low of 36% in Alberta to a high of 81% in PEI and Quebec.

Table 1

Province/Territory	Electronic Charts Instead of Paper (%)	Paper Charts (%)	Combination of Paper and Electronic Charts (%)
NL	9	46	36
PE	0	81	13
NS	11	59	25
NB	6	75	17
QC	2	81	13
ON	13	61	22
MB	24	56	14
SK	13	70	13
AB	33	36	26
BC	14	62	21
Territories	**	**	**
CANADA	12	63	19

**Suppressed due to low cell frequency (ie. n<30) but included in national total

Source: College of Family Physicians of Canada, Canadian Medical Association, Royal College of Physicians and Surgeons of Canada, National Physician Survey, 2007, Q39.

Internationally, the Commonwealth Fund has shown that Canada lags far behind comparator countries in the uptake of electronic medical records (EMRs). On its 2006 survey of primary care physicians in seven countries, fewer than one out of four (23%) Canadian respondents reported that they used EMRs in their offices compared to nine out of ten in the UK, New Zealand and the Netherlands.⁴⁹

Aside from the issues of wait times for those patients with a family physician there is also the challenge of capturing information about access to primary medical care for those without their own family physician.

E. Practice Support

Improvements in access to family physicians can also be accomplished through the addition of staff support, of which there are two types:

1. clinical practice support (ie nurse or MOA for patient care), and
2. change management practice support (those with knowledge of clinical practice redesign to support physicians in making, monitoring and sustaining change).

The Practice Support Program in British Columbia offers training and financial incentives for family physicians working with medical office assistants and in one district health authority in Nova Scotia, a project is underway where family physicians can obtain financial support to employ family practice nurses through enhanced fee-for-service billings. At present, however, widespread deployment of practice support personnel is constrained by rules of fee-for-service payment that require the physician to have direct contact with each patient for whom a service is billed to the provincial or territorial medicare plan.

In terms of change management practice support, thus far CPR has had limited uptake in the rest of the country, primarily due to a lack of awareness. However, stories of the successes with this program are now being heard in the rest of the country and it is increasing in popularity. For example, a new Advanced Access initiative has been recently introduced in Manitoba through their Ministry of Health. In Nova Scotia, one practice that has had great success with Advanced Access is managed by the 2008 recipients of the Health Care Provider of the Year Award in Cape Breton, Elaine Rankin and Steven MacDougall. They worked together on an Advanced Access research project beginning in 2006. Once Dr. MacDougall cleared his patient wait list, he began to operate a same day access practice where his patients can call in the morning for an appointment that day. Now, the number of non-urgent patients from his practice who go to the emergency department has dropped by 28%.⁵⁰ By all accounts, those who have implemented CPR indicate they would never return to the traditional model where the appointment schedule is full before the work day starts.

CPR is not a tool to be used exclusively in family practices. The group urology practice in Saskatchewan that introduced the notion of pooled referrals with much success has also been engaged in the process of CPR since early 2007. Their practice is now beginning to enjoy the fruits of their labour through reduced wait times for patients who are referred to their practice. The “champion” of this undertaking, Dr. Visvanathan, noted that Clinical Practice Redesign involves improving practice work flow, the introduction of Electronic Medical Records and getting the right staff to do the right jobs.⁴⁰

The implementation of a more efficient practice management system such as CPR requires commitment from physicians as well as effective information management and measurement tools, additional practice support and assistance from change management experts. Experience to date suggests that these efforts pay off in terms of improved patient access and increased capacity to accommodate patient appointments.

Recommendations

There are three main issues that should concern our focus on primary care wait times:

- Access to primary care for those without a family physician;
- Access to primary care for those with a family physician; and
- Referral from primary to more highly specialized care.

There are general recommendations that would help address these issues and other recommendations that are more specific to each. This paper has provided valuable information that supports the following recommendations.

General Recommendations

As noted in the introduction to this paper, it is difficult to measure primary care wait times for myriad illnesses and conditions, and this difficulty may impede progress in finding solutions to the wait time challenges that family doctors experience. The Primary Care Wait Time Partnership (PCWTP) believes that the ability to measure and track wait times along the full continuum of the patient's care is of utmost importance, but that this capacity in primary as well as more highly specialized levels of care is still very limited.

- 1) Primary care wait time tracking, analysis and improvements should be **patient-centred**, taking into account the whole wait time continuum that patients experience, starting from the time they first seek medical care.
- 2) **More research and evaluation** is needed to analyze primary care wait times so that the inequities and inconsistencies in access to care can be addressed for patients from region to region across Canada.
- 3) **More study on collaborative care is necessary.** The PCWTP recognizes that collaboration has the potential to enhance access to primary care. But before we can state with certainty that access to primary care is improved through particular models of care delivery, we need to continue to collect data and analyze results. It makes little sense to invest tremendous resources into any model if patient access to primary care is not improved.
- 4) **Primary care wait time measurement should be a priority** for Canadian governments, health authorities and other stakeholders, (e.g. Canadian Institute for Healthcare Information). Reliable data that represents the patient's total wait time experience will need to be collected to support the development of primary care wait time targets in the future. This data must be validated and tracked for the purpose of continuous evaluation.
- 5) Before reasonable wait time targets can be established and effectively used in primary care, **information infrastructures, (e.g. electronic medical records and communication tools)**, must be adequately supported and in place. Enhancements in information technology and learning in family practice will be necessary to facilitate the adoption and widespread use of electronic medical records. No measuring or tracking of primary care wait times can be effectively accomplished without financial support from government for electronic communication systems in and between medical practices.

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- 6) There are a number of jurisdictions pursuing important and **different ways to improve timely access** to care for patients, (e.g. Manitoba's catalogue system and registry tool, Alberta's formal service agreements between referring and consulting physicians). These worthwhile endeavours should be monitored at a national level for opportunities to implement more universal improvements to wait times in our Canadian health care system.

Recommendations for Patients without a Family Physician

The CFPC and CMA have recommended and supported several strategies to increase the supply of family physicians through education and training (e.g. promotion of family medicine to medical students and residents, better support for preceptors and teachers), to address changing patterns of family practice (e.g. supports for inter-professional collaboration), and to develop models of care that would attract and retain family physicians (e.g. blended remuneration methods). While these recommendations will not be repeated here, they should be given full consideration in seeking to achieve an adequate family physician workforce that can support timely access to care for all Canadians.

- 1) The PCWTP believes that every Canadian should have a family doctor and supports the CFPC position that all stakeholders, (e.g. governments, medical schools and professional organizations), should work together to achieve a **target of 95% of the population in every Canadian community with a family doctor by 2012**.
- 2) **Patient registries** should be developed and maintained to track patients who do not have a family doctor and are actively looking for one.
- 3) Other strategies should be more fully developed and supported to **find family doctors for patients without a family doctor**, (e.g. physician incentives to accept new patients and the use of tools for workload management and patient flow in family practice).
- 4) Efforts currently underway to **integrate appropriately trained and certified international medical graduates** as family physicians into our health care system are welcome, should be supported and enhanced.

Recommendations for Patients who have a Family Physician

- 1) Family physicians who see a need to improve timely access to care for their patients could consider **Clinical Practice Redesign tools such as Advanced Access**. System support should be in place for family physicians who want to adopt these tools. The training and ongoing learning of new and practicing family physicians should include education in practice flow and design. To further assist physicians in the use of these tools, websites should be established with lists of those who have been successful at improving patient flow through their practices and who are willing to assist others attempting to do the same.
- 2) **Practice management education and training** should be enhanced in residency in order to teach new family physicians about effective office processes and practice flow efficiencies that improve timely access to care for patients, (e.g. electronic tracking tools).

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- 3) Financial incentives should be available to **support the valuable roles of office assistants as well as other health professionals** in family practice, (e.g. family practice nurses), for better patient flow and more efficient use of the physician's time. In addition, family physician remuneration should compensate for patient encounters beyond just face-to-face in order to support increasingly important opportunities for electronic encounters with patients and members of the care team.

Recommendations for Referral from Primary to Specialty Care

- 1) All recommendations to address timely access to more highly specialized care must **include the wait time from the first visit with the family physician** to referral and specialty consultation.
- 2) Based on four years' experience with benchmarks for the five procedural areas established in 2004, we do not believe it is possible to develop a broad array of condition-specific, evidence-based benchmarks for access to consultations in the near future. However, where they are or do become available and are supported by sufficient infrastructure, **wait time targets should be used as guides** to drive improvements in timely access to care. Nonetheless, family physicians must continue to be free to use their clinical judgment in the patient's best interests.
- 3) **Good intra-professional relationships between family physicians and other specialists** should be promoted and supported in the health care system to improve communications and the continuity of care for patients. Strategies to support good relationships should consider recommendations that have been developed by the Canadian Medical Protective Association as well as the Collaborative Action Committee on Intra-professionalism that is supported by the CFPC and Royal College of Physicians and Surgeons of Canada with CMA participation.
- 4) **Tools that will improve the timeliness of the referral-consultation process** between physicians should also be enhanced; however, any development of referral-consultation process tools **must** be undertaken collaboratively with family physicians, (e.g. referral-consultation frameworks that identify and support the availability of appropriate and timely information to and from referring and consulting physicians, electronic communication of patient information between physicians, and better system supports for electronic communication between physicians and patients).
- 5) Family physicians should have **access to routine and advanced diagnostic tests** for their patients in all clinical settings, equal to that of other specialists. There should be no difference in the criteria for access to advanced diagnostic testing from region to region. All physicians should be expected to follow appropriate clinical guidelines in the use of diagnostic tests. These guidelines should be readily available and easily understood by physicians and other health care professionals with whom they work.
- 6) Guidelines or targets for timely access from primary to specialty care must account for **differences in geographic settings and proximity to care** that are characteristic of rural and remote locations in contrast to urban and suburban locations.

Concluding Remarks

While the Canadian Medical Association (CMA) and The College of Family Physicians of Canada (CFPC) are proud to represent doctors across Canada, at the centre of everything we do stands the patient. We know that many Canadians are concerned about timely access to see their own family doctor while others continue a sometimes fruitless search for a family doctor of their own.

In this paper we have presented many problems but also a number of solutions to addressing wait times in primary care. We've acknowledged that there are obstacles, but we do not think these obstacles are insurmountable. Canadians exercised considerable political courage, often in the face of adversity, to pioneer a health care system based on the principles of fairness, equality and social justice. Through political will, we are certain we can make the changes necessary to ensure timely access to primary care.

The PCWTP hopes that governments, health care providers and the public will read this report and consider the recommendations. We know that these recommendations do not represent an exhaustive list and indeed we may have inadvertently omitted something you think is critical. We encourage you to let us know what you think and how we can work together to improve access to primary care.

This is not a task merely for the CFPC or the CMA; all of us must work together to offer better access to health care to our patients.

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