FÉDÉRATION
DES MÉDECINS
OMNIPRATICIENS
DU QUÉBEC

WORKING GROUP REPORT ON ACCESS TO PRIMARY CARE

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Individuals consulted

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LIST OF ABBREVIATIONS

AMP	Activités médicales particulières (Specific Medical Activities)
CLSC	Centre local de services communautaires
CSSS	Centre de santé et de services sociaux
EMR	Electronic Medical Record
DRMG	Département régional de médecine générale (Regional Department of General Medicine)
FMOQ	Fédération des médecins omnipraticiens du Québec
FMG	Family Medicine Group
LSSSS	Loi sur les services de santé et les services sociaux
PROS	Plan régional d'organisation des services (Regional Services Organization Plan)
RLS	Réseau local de services (Local Services Network)
PAU	Population-based Access Unit
FMU	Family Medecine Unit

MESSAGE FROM THE PRESIDENT OF THE WORKING GROUP ON ACCESS

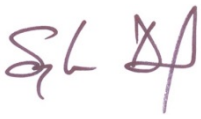
La Fédération des médecins omnipraticiens du Québec (FMOQ) plays a leading role in the organization of health care in Québec. Thanks to its policy of promoting family medicine that it launched five years ago, it has breathed new life into front-line medical services.

The issue of access to primary care, however, remains a preoccupation. With this Report, the FMOQ submits a proposal that will resonate deeply with family doctors and Québecers: put primary health care at the heart of the practice of family medicine in Québec.

At the centre of a social contract that links family doctors with citizens, comprehensiveness , continuity and access to primary health care are essential. These three priorities the cornerstone of our proposal, which relies on our network of medical clinics, FMGs, network clinics, CLSCs and Family Medicine Units. Our plan is not to revolutionize the primary care network, but to consolidate its components, while strengthening the ties between the network of institutions.

It is a dynamic project that is feasible in the medium term, both for the medical community, which will have to assume greater responsibilities and the government that will need to support it.

We submit this plan with a view to meeting the needs of Québecers. The FMOQ and family doctors are ready for the challenge.



Sylvain Dion, M.D.
Executive Director
Fédération des médecins omnipraticiens du Québec

I. THE WORKING GROUP AND ITS APPROACH

Context

Over the past several years, the FMOQ has made promoting family medicine one of its biggest challenges. With some two million Québecers in need of a family doctor in 2010, it was more than time to act. The FMOQ immediately got down to work and successfully implemented a series of measures that touched on training, organization of practice and remuneration.

In a world where health care consumption is constantly evolving, family doctors face another challenge: access to front-line medical services. In fact, even though many orphan patients were able to register with a family doctor over the past several years, access to them has too often remained problematic. Long wait times to consult a doctor as well as access to the services of a doctor in the evening, on weekends and on statutory holidays are the chief problem.

Faced with this fact, the FMOQ created a working group. Its mandate: propose a model that aimed to improve access to front-line medical services. The model had to apply to all family doctors, while fitting into existing structures.

Mandate

Developed by the President of the FMOQ and under the authority of the Bureau of the Fédération, the Working Group on Access was mandated to:

1. consider the reality of different regions.
2. improve access.
3. take into account existing organizational models.
4. encourage family doctors to adopt the new model.
5. identify the links needed between the proposed organizational model and the local network institutions.
6. define the support needed for the model to function efficiently.
7. determine the role of other professionals.
8. determine the number of organizations needed in Quebec's different health regions.

With regard to doctors especially, the Working Group had to:

1. estimate reasonable access that doctors should offer to their patients in urgent, semi-urgent or non-urgent situations.
2. determine incentives required to encourage doctors to adopt this new model and anticipate communication mechanisms needed between the different doctors of the region of an RLS.
3. propose remuneration plans facilitating access, while taking into account existing agreements.

The approach adopted by the Working Group

The Working Group agreed to divide its approach into two parts:

- gathering information
- defining and developing the new model, based on the findings

Information gathering

Good access to primary health care is not an easy concept to define. It is greatly influenced by the scope of perceptions and realities of each of the stakeholders involved: the population, the doctors and the managers.

To better comprehend these perceptions and realities, the Working Group began by conducting surveys. Following this, a series of consultations were conducted with groups and individuals recognized for their expertise and credibility.

The surveys

The firm Léger Marketing was mandated to assess the usual wait times and those the population of Québec deemed acceptable for consulting a family doctor. Concurrently, another similarly-themed consultation was sent electronically to family doctors in Québec. The number of respondents was 1,000 Québecers and 1,344 family doctors, respectively, constituting a significant reply rate.

In general, doctors and the population recognize that access to front-line medical services is an issue. The survey indicates that 93% of doctors share this opinion. In particular, we note that:

1. 45% of family doctors who provide care for patients say they offer non-urgent consultations in over a month's time.
2. 29% of family doctors who provide care for patients say they offer non-urgent consultations within two weeks.
3. 94% of family doctors who provide care for patients feel that the wait time for an appointment for a non-urgent consultation should be within a month.
4. 80% of the people surveyed would like to see their family doctor for a non-urgent consultation within less than a month.
5. 61% of family doctors who provide care for patients feel that an acceptable wait time for a non-urgent consultation is less than two weeks.
6. 55% of family doctors who provide care for patients say that they are unavailable for a same-day urgent consultation.
7. 66% of family doctors would like their patients to be able to see them for an urgent medical consultation or another doctor from the same group, on evenings, weekends and statutory holidays.
8. 63% of patients who responded said that when a same-day urgent consultation was needed it was impossible for them to see their doctor or another doctor from the group.

Individuals and consultants met

To obtain different points of view as well as steer and fuel discussions among the working group, a number of people were consulted:

- Representatives from the Département régional de médecine générale
- Members of the FMOQ's Young Physicians Committee
- Mr. Paul Brunet and Mr. Gabriel Dupuis from the Conseil pour la protection des malades
- M. Alain Dubuc, columnist for the newspaper *La Presse*

Mr. Alain Dumas, Ms. Vicky Wong and Mr. Simon Pouliot, from the firm KPMG-SECOR, consultants retained by the FMOQ, conducted an economic feasibility study of the project.

Lastly, the Working Group was able to benefit from the expertise of Mr. Roger Paquet, former Deputy Minister of the Ministère de la Santé et des Services sociaux. Mr. Paquet accompanied the Working Group throughout the discussions to evaluate and comment on the service proposals that were put forward.

Three broad findings emerged from these consultations:

1. Doctors and patients have somewhat different perceptions of access to primary health care.
2. Patient care is relatively well-structured by the FMGs.
3. Few alternative solutions exist to a hospital emergency department in the following circumstances :
   - for an urgent or semi-urgent consultation during unfavourable hours on Saturdays, Sundays and statutory holidays
   - for a consultation requested by a patient without a family doctor

More specifically, these findings can be divided into three broad categories: those pertaining to the general population, those pertaining to doctors and finally, those pertaining to the organization of services.

Findings

General population

1. For many Québecers, access can be defined as a continuum of health care services where the family doctor plays a key role.
2. Patients would like to be followed by a multidisciplinary team led by a family doctor.
3. Patients are not well informed of the services offered by the primary health care services network.
4. Little is known about the multiple tasks of family doctors.
5. When it is a question of providing more funding to primary care, no distinction is made between remuneration and support for professional practice.
6. Access includes all measures implemented to facilitate a patient's efforts in obtaining these services

Doctors

1. Doctors would like to be more accessible.
2. Young doctors bring up family obligations with regard to working during unfavourable hours.
3. Teamwork is essential.
4. On an individual basis, doctors are more focussed on managing supply than on managing demand.
5. Accessing services, when and where they are needed, is problematic. All too often, doctors only see their patients during an annual check-up.

Organization of services

1. Access comes into conflict with institutional obligations and AMPs.
2. Front-line health care is limited by its physical capacity and material resources to adequately care for patients in the L4 and L5[1] categories.
3. Difficulty in accessing specialized services and ancillary services leads to significant loss of time for primary care doctors and unjustified wait times for patients.
4. The coordination and dissemination of information throughout the network is a major impediment to continuous health care.
5. The distribution of patient traffic between clinics could be improved.
6. Professional support is lacking in many practice settings.

[1] **Triage and acuity scale (TAS)**
L1: **Immediate care** by the on-site team. Conditions that are threats to life of a patient.
L2 : **Rapid and urgent.** Conditions that are a potential threat to life of a patient.
L3 : **Urgent.** Conditions associated with significant discomfort or affecting a patient's activities of daily living.
L4 : **Semi-urgent**. Conditions that are not any threat to patient's life, but could represent potential for deterioration or complications.
L5 : **Non-urgent**. Conditions that do not present any threat to patient's life.
Source: www.amuq.qc.ca

II. THE WORKING GROUP PROPOSAL

The Working Group proposal is aimed at all family doctors and would significantly improve access to front line health care across Québec in two ways:

1. For an existing patient, access to **his/her** family doctor or, exceptionally, to a doctor from the same group.

2. Access to **a** family doctor.

A) The cornerstone of the proposal: access to a patient's family doctor (or, exceptionally, to a family doctor from the same group)

Healthcare management, particularly through FMGs, encourages patients to consult their family doctor or a doctor from the same group. However, even patients registered with a doctor often have a difficult time seeing them. The goal of the proposed measures is to support doctors in their practice and streamline the management of appointments. Registering patients with a family doctor falls within a context of healthcare management, comprehensiveness and continuity. For a number of years now, the FMOQ has been promoting this principle. The Working Group does not question this fundamental principle whatsoever.

Furthermore, whether they work in a FMG or not, all doctors providing care to patients should be able to benefit from the services of a nurse. Therefore, it is proposed that every family doctor have recourse, under certain conditions, to nursing services the equivalent of 0.5 days per week per 1,000 registered patients.

The conditions previously mentioned would require that agreements be reached regarding obligations required for the smooth operation of primary health care services in an RLS. The goal of these agreements, whose conditions are outlined in more detail on page **11** of this document, is not only to improve access, but also to provide care for orphan patients and to group doctors together.

By improving wait times, doctors could see their registered patients in urgent and non-urgent situations. To that end, a bonus would be paid doctors whose appointments were scheduled, for their registered case load, in a time frame of less than three days. To make themselves more accessible, doctors would be encouraged to free up a minimum of three appointments a day. We imagine that various formulas will be put forward. Consider, in particular, advanced access and its variations. In terms of software, new possibilities exist to improve service management.

Thanks to Electronic Medical Records, doctors now benefit from administrative support in managing their practice, while streamlining coordination of care with other professionals. As for patients, various systems for making appointments and distributing patient traffic were created to help them find a physician.

According to the Working Group, the modes will be available to all doctors, whether they practice in a FMG or not. It is important to clarify that the preferred formula for consolidating front-line health care services in Québec remains the FMG model. Moreover, the Working Group is pleased to note that the FMG management framework will be reviewed in collaboration with the FMOQ. It sees this

as an excellent opportunity to improve upon the model while offering better patient care and access to front line health care services.

These solutions, which are concrete and attainable in the short-term, would encourage doctors to change the way their practice is organized and adopt new tools.

B) The safety net: access to a family doctor

Primary health care structures must allow the population, whether registered or not, to have their health care needs met quickly. These structures must be particularly well adapted to large urban centres, where orphan patients are found most predominantly.

Based on their findings, the Working Group proposes the creation of Population-based Access Units (PAU) that would be integrated and streamlined with existing health network structures.

Population-based Access Units (PAU)

The PAU is a site where all patients would have rapid access to a medical consultation. The need to create PAUs in the region of an RLS would depend on the needs identified in the regional organization plan of general medical services. In principle, a PAU's services would be concentrated in one and the same building.

The PAUs, preferably, would join the already existing network; for example, an FMG, a medical clinic, a CLSC or a network clinic. The manner in which they operated would depend on a series of mechanisms linked to all of the RLS's resources. Under the clinical responsibility of family doctors, PAUs would preferably be owned and run by the latter.

The PAUs would act as a security net that would allow all patients, whether registered or not, to get access to primary health care in less than 24 hours. The anticipated framework foresees:

1. 76 hours of medical access per week, divided over a 7-day period
2. The assistance of a nurse at all times in a PAU
3. Appointment management with an on-site wait time of less than two hours

These organizations would accommodate, on an outpatient basis, all patients in need of a doctor's services, including Level 4 and 5 patients on an emergency department triage scale. Collaborative mechanisms would allow PAU doctors or partner doctors to facilitate care of orphan patients.

Doctors working in a PAU would have access to specialized consultations and ancillary services that would include on-the-spot imaging tests and laboratory analyses as well as their results. Depending on the practice setting and patient traffic, patients would be directed to the proper services by liaison personnel or according to the terms of an "*accueil clinique*".

As noted earlier, PAUs would preferably offer on-site patient care services. This, however, would not be a prerequisite for the creation of a PAU. Those that didn't offer on-site patient care services would, nonetheless, need to reach an agreement with another practice setting in order to redirect orphan patients in need of care.

Service agreements

Service agreements would be central to how a PAU functioned. In fact, the creation of the latter would depend on agreements reached with care management structures such as FMGs, offices, FMUs and CLSCs as well as agreements made with CSSSs.

In particular, these service agreements would cover:

1. the hiring of partner doctors for the PAU (a commitment translating into hours of on-site service or care of orphan patients managed by the PAU)
2. the commitment of the CSSS for access to ancillary services
3. the commitment of the CSSS for access to specialized consultations
4. the commitment of the CSSS for allocating human resources

In exchange for services rendered to the UAP, doctors would benefit from nursing support (0.5 days a week per block of 1,000 registered patients). Non-pecuniary compensation would essentially aim to support doctors with managing and monitoring their caseload.

Lastly, different kinds of incentives would help to encourage doctors to reach an agreement with the PAUs:

1. recognition for patient registration
2. bonuses from a CSSS's "guichet d'accès" for taking orphan patients
3. bonus incentives for work carried out during unfavourable hours, Saturdays, Sundays and statutory holidays
4. recognition for work carried out in a PAU for AMPs

The role of the DRMG

Agreements acceptable to doctors would be at the heart of the proposed organizational model. To this end, it is important to entrust the role of managing the model to a competent entity, both on a RLS-basis as on a regional basis. According to the Working Group, the *Loi sur les services de santé et les services sociaux* already identifies and names this organization: the DRMG.

Composed of all family doctors from one region, the DRMG should play a leadership role. It should ensure that contractual arrangements meet the identified and anticipated needs in primary health care. To do so, it would fully assume the responsibilities entrusted to it by the legislator including, in particular:

1. Developing a regional organization plan for general medical services that would specify, for each RLS in the region, the nature of existing services regarding access and care of different clienteles.

2. Developing an access network to general medical care that would fall within this regional organizational plan of general medical services.

The DRMG would play a leadership role before developing a PROS and an access network. It would also play a role after since it would validate, according to the PROS and the network, all service agreements that doctors from an RLS might reach with a PAU, a CSSS or an office.

More specifically, the DRMG would determine the location, the number of PAUs needed in its region as well as the minimum conditions required to operate them, including physical lay-out. It would also approve the service offer, and foresee certain terms, for example, the number of doctors required for it to operate efficiently. Lastly, it would use AMPs, a tool developed for doctors to guide their activities, to support the organization of the PAUs.

This model assumes that the DRMG can also be assisted, in concrete terms, by the different CSSSs of its region. It is important that the latter offer conditions that would allow doctors convenient access to the required ancillary services, clinical information, other specialists and nursing personnel.

For the Working Group, the DRMG, in collaboration with the regional medical associations affiliated with the FMOQ, would be an important stakeholder in the proposed model. These structures are also the only ones capable of grouping doctors from the same region together.

The role of the CSSS

The LSSSS confides an important role to the CSSSs, which must assume responsibility for and help coordinate services offered to the population within its territory. In fact, the LSSSS stipulates that CSSSs create favourable conditions for access to:

1. diagnostic testing and services for all doctors
2. patients' clinical information
3. diagnostic test results such as lab results and medical imaging tests
4. services of a specialist
5. nursing personnel

Implementing these mechanisms would be outlined in the service agreements reached between CSSSs and doctors, following approval by the DRMG. The agreements would specify procedures for disseminating information between parties, bilateral referral mechanisms as well as communication, while ensuring a system of accountability.

CONCLUSION

The FMOQ and family doctors are very concerned by the difficulties the population experiences in accessing primary health care. All too often, patients have a hard time obtaining services when they need them. Doctors, for their part, work in less than optimal conditions.

The Working Group on Access to Primary Health Care has conducted a rigorous analysis of the situation while taking into account the realities of the current health system. It feels that it has identified dynamic and realistic solutions to the existing problems of coordination, continuity, complementarity and access.

The proposed organizational model would consolidate Québec's primary health care network. While Population-based Access Units (PAU) would ensure the link between different care settings and hospitals, the mecanisms proposed to support them would decompartmentalize practice structures and improve collaboration, comprehensiveness and continuity of care.

The Working Group feels that if Québec's family doctors appropriate this model, it will not only increase their sense of satisfaction and that of other health professionals but, above all, that of the population in light of persistent organizational problems. The success of this proposal rests on the invaluable contribution of the DRMGs, the doctors who adopt this model and the balance that is maintained between sectors, particularly between primary and secondary health care.

RECOMMENDATIONS

Recommendation no. 1

For an existing patient, facilitate access to his/her family doctor (or, exceptionally, to a doctor from the same group)

Objective:
That all Québecers registered with a family doctor can obtain a medical consultation with their doctor in less than three days.

Conditions required to reach this objective

1. That family doctors providing care to patients receive a bonus for appointments scheduled in a time frame of under three days for their registered patients in need of a quick consultation
2. That doctors can freely choose the working mode that would allow them to attain this objective: advanced access, for example
3. That each family doctor providing care to patients benefit from nursing services equivalent to 0.5 days per week per 1,000 patients
4. That the family doctor must, in turn, be part of an access network or take orphan patients from this network
5. That the doctor who has joined the front-line health care access network or who accepts to take new patients is automatically recognized for number of patients registered
6. That the participating doctor who accepts orphan patients is eligible for bonuses for the care of orphan patients as provided for by the "guichet d'accès"
7. That each CSSS will reserve blocks of time for ancillary services and specialized consultations for patients of family doctors.

Recommendation no. 2

Facilitate access to a family doctor

Objective:
That all Québecers, whether registered with a family doctor or not, have access to a family doctor in less than 24 hours for a semi-urgent consultation.

Conditions needed to reach this objective

1. The creation of a safety net through Population-based Access Units, which would give individuals access to a family doctor 76 hours a week, over a 7-day period
2. Daily appointment management through an automated device, ensuring on-site wait times of under two hours (in PAUs)
3. Assistance of a nurse at all times in PAUs.
4. Implementation of collaborative mechanisms to facilitate care of orphan patients.
5. Access to specialized consultations and to adequate ancillary services for doctors working in a PAU.
6. A bank of paid hours for the doctor responsible for a PAU and its participating doctors
7. Recognition of number of registered patients for doctors participating in a PAU
8. Recognition of PAU activities toward AMPs for participating doctors.