

Survey on Family Physicians & Seniors Care in Alberta Report August 2009

1.0 INTRODUCTION

Alberta Health and Wellness and Alberta Seniors and Community Supports recently announced a new model for delivering services to seniors: “Continuing Care Strategy - Aging in the Right Place”. These departments will be working collaboratively with Alberta Health Services and providers of health and accommodation services to implement the recommendations. In addition, Alberta Health Services is developing strategies for seniors’ care in Alberta based on the recent McKinsey Alberta Service Optimization Review. We believe it is vital for family physicians to have the opportunity for informed input to decision making and policy development affecting seniors care in Alberta.

The Alberta College of Family Physicians (ACFP) established a Care of the Elderly Committee in 2001. The Committee is composed of community and academic family physicians with a commitment to providing high quality care to seniors with chronic and complex conditions. Committee members represent rural areas and regional and urban centres throughout the province. Members share and discuss issues and new developments, and seek to demonstrate local and provincial leadership by sharing their knowledge and learnings with all family physicians in the province and with other health disciplines involved in caring for seniors.

The ACFP Care of the Elderly Committee designed the “Family Physicians & Seniors Care in Alberta” survey as a first step in identifying major barriers and potential solutions in caring for the elderly and their multiple needs. The survey queried members of the Alberta College of Family Physicians on their opinions about the care they currently provide to seniors. They were also asked about their concerns and suggested improvements for care of seniors in the future.

2.0 PURPOSE/OBJECTIVES

The survey was developed as a significant opportunity to generate a preliminary profile of family physicians caring for seniors and to provide valuable feedback that will inform the decision-making and policy development affecting seniors care in Alberta.

The main purposes of the survey are to (1) gather a baseline of data on family physicians caring for seniors, (2) demonstrate to decision- and policy-makers that the ACFP Care of the Elderly Committee is a credible voice on seniors care, and (3) provide feedback to the Committee as it develops goals and strategies for the coming months and year.

3.0 SURVEY METHODOLOGY

Invitations to reply were sent to all current members of the Alberta College of Family Physicians with email addresses excluding medical students and residents. The survey utilized the Web based program “Survey Monkey” (www.surveymonkey.com) to design the survey and gather the responses. The survey was distributed by email by the Alberta College of Family Physicians in February 2009 with responses received in February and March 2009. Out of a possible reply group of 1856 Family Physicians, 196 (10.5%) responded.

The survey questions included respondent demographic identifiers, number of seniors on their patient list, type of remuneration and their satisfaction with the remuneration, opinions regarding various types of support (system, office and Community Care system) and challenges present and changes required to enable the respondents to enhance their capability to care for the elderly.

4.0 RESULTS

4.1 CHARACTERISTICS OF SURVEY RESPONDENTS:

- 90% are in full-time or part-time medical practice.
- 75% work in a private office or clinic (excluding free standing walk-in clinics).
- 68% are in an urban/suburban care setting. A greater proportion of female respondents are in urban settings and more male respondents in rural areas.
- 65% see more than 15% seniors in their total patient panel.
- 64% of the respondents work in a Primary Care Network.
- 58% are female.
- 31% are in the 30-39 age bracket and 30.8 % are in the 50-59 age bracket.
- 16% of the respondents serve in a leadership role in settings that support elderly patients. A greater proportion of those in a leadership role are male.

4.2 FUTURE CHANGES IN AMOUNT OF ELDERLY CARE:

- 95% of the respondents indicate the proportion of elderly patients that they see has increased in the past 10 years.
- 85% of the respondents who indicated the proportion of elderly patients has increased in the past 10 years expect the proportion to continue growing.
- 81% of the respondents do not intend to reduce the proportion of elderly patients they treat over the next 5-10 years.
- 19% of the respondents do intend to reduce the number of elderly patients; approximately 78% of those respondents indicated that age, retirement or semi-retirement would be the reason.

"I am not accepting any new patients, but my current patients are aging and I will keep them on."

"I plan to semi-retire, possibly leaving the province, in 3 years."

4.3 SUPPORT SYSTEMS:

- 76% of the respondents noted that the Community Care system is not currently meeting the living needs and medical needs of their patients. Gaps were mainly identified as long wait lists for long term care placements and lack of home care.
- 50% of the respondents are not satisfied or very unsatisfied with the system supports they require to manage the care of older patients e.g. assessment and referral clinics; rehabilitative care; transportation.

"For the elderly who need LTC, but remain in their own homes, there is inadequate home care in the community. They frequently end up staying for long periods in acute care, where they decline functionally."

"Home care works reasonably well but has increasingly apparent stress in meeting new demands. Long term placement continues to be a significant problem with apparent lengthening of time for placement when needed and difficulty in getting seniors to meet requirements due to apparent increase in the needed care level to allow acceptance of applications."

4.4 REMUNERATION:

- More family physicians in metropolitan areas are on an ARP/Blended ARP + FFS and more family physicians in regional/ rural areas are paid by Fee for Service.
- A higher number of younger physicians (29-39 years) and female physicians seem to be on an ARP/Blended ARP+FFS payment method than older physicians.
- 75% of the respondents are currently paid by Fee for Service but 66% of those respondents are not satisfied with the current FFS system as a payment method for providing care for seniors.
- 63% of the respondents who are not currently on an Alternate Relationship Plan would be interested in an ARP for physicians caring for seniors. 73% of those interested respondents are female.
- Concerns were also expressed around the remuneration for support staff such as Personal Care Attendants and other bedside care attendants.

"Continue to develop Alternative Funding for physicians to work with the frail elderly in all settings e.g. Long term care, Assisted Living and Home Care in the community"

"Multi disciplinary team approach needed with funding to sustain a team approach. Alternate payment plan remuneration for physicians. Excellent, well staffed community nursing services."

4.5 MAIN AREAS OF CONCERN: “TIME” & “MORE”

The most challenging aspect in seniors’ care was frequently recorded as “**TIME**” in three (3) main areas:

- time required to adequately care for patients with complex, multiple problems (medical, social and psychological, etc).
- time required to access placement in an appropriate, adequate and safe setting.
- time required to access support services such as home care, occupational therapy, etc.

“Amount of time to address all of their needs in one visit”

“Complexity of care and lack of time to fully assess needs and address issues”

“The amount of time it takes. The logistical difficulties in arranging visits, lab and diagnostics as well as communicating with family members”

The majority of comments provided by the respondents mentioned “**MORE**” as a description of the changes needed in three (3) main areas of concern:

- more support of multidisciplinary teams and patients to prolong living in the home.
- more and better ways to remunerate physicians for care of the elderly in all capacities e.g. clinic visits, home visits, long term care visits.
- more long term care facilities with qualified staff that are paid adequately.

“more money, more support, more facilities, more staff”

“More recognition of the difficulties accessing limited services and the time commitment needed by us and families”

“more recognition in funding/ fees, more funded health care workers e.g. physio & OT in the community”

5.0 DISCUSSION

This survey of family physicians in current practice in Alberta, from city and rural areas in proportionate numbers, found that the vast majority had experienced an increase in the number of seniors in their practice in the last 10 years. Most expected this number to continue to rise in the near future. Two thirds have patient panels with more than 15% seniors. Most intend to stay in practice. Most would consider alternate payment methods as a means of reimbursement and did not feel that fee for service properly compensated them for the care of seniors. Most did not feel that the system was currently able to meet the living and medical needs of their patients. There would appear to be a need to urgently address the concerns of physicians who care for older patients in the community and find solutions to support their ongoing commitment to patient care.

Physicians responding to the survey wish to continue this critical work but it is difficult to do without the proper supports and collaboration from other providers working in a fully integrated system of care that puts the patient at the centre of all decision points. What are family physicians asking for in this survey?

- (1) More supports to practice
- (2) More choice on physician reimbursement models
- (3) A better system of support for patients with chronic care needs living in the community
- (4) Appropriate placement options on a timely basis
- (5) Better access to support services in the community
- (6) More team supports

“Increased support from home care and home lab collections, transportation for appointments and diagnostic tests, increased training of staff in seniors’ residences, higher numbers of staff in seniors’ residences.”

6.0 RECOMMENDATIONS & NEXT STEPS

The ACFP Care of the Elderly Committee reviewed the findings of this survey. Based on these findings and the experiences and expertise of Committee members, it is recommended that on behalf of the ACFP, the Care of the Elderly Committee:

1. Develop a vision for seniors care and the modern role of the family physician.
2. Continue to study the medical needs of seniors in the community.
3. Continue to study the practice of physicians providing care to seniors.
4. Advocate for improvements to seniors care with key decision-making groups.
5. Advocate for all family physicians providing care to older adults in the community and hospital settings.
6. Identify key community, government, professional and voluntary agencies and associations to establish areas of commonality and future collaboration.
7. Make preparations to consider the impact of Continuing Care Strategy on physician practice and make plans to address concerns of physicians.
8. Support the principle of seniors living independently to their fullest potential in their own home or community.
9. Advocate for financial supports and/or incentives to develop and implement alternate relationship plans.
10. Encourage more family physicians to enroll in care of the elderly training programs and CME courses
11. Support models of practice that promote collaborative care
12. Support systems of care that promote integration of services

APPENDIX 1 ACFP Care of the Elderly Committee

Background and Role

- Committee serves as a unique forum for family physicians to discuss initiatives and issues in planning and providing care for the elderly patient with complex needs.
- Has been in existence for eight years
- In 2002, released a paper that identified the current situation and limitations of the current system in relation to: (a) the role of family physicians in caring for the elderly, (b) the role of the College in caring for the elderly, and (c) the role of the university (educational) in training family physicians in caring for the elderly. This was followed by a description of the desired future, and recommendations that focused on closing the gap. These recommendations for the most part, are applicable today.
- Committee is composed of community and academic family physicians with a commitment to providing high quality comprehensive care to seniors with chronic and complex conditions
- Members represent rural areas and regional and urban centres throughout the province.
- Communication is by email and in person meetings.
- As the voice of family physicians providing seniors care, members:
 - (a) demonstrate local and provincial leadership by sharing their knowledge and learnings with all family physicians in the province and with other health disciplines involved in caring for seniors, and
 - (b) inform the strategies and programs under development or being considered by AHS and government by participating in various planning and policy development venues.

Current Members:

Diana Turner (Chair)	Calgary
Jeremy deBruyn	Calgary
David Belcher	Drayton Valley
Mary Hurlburt	Edmonton
Christine LeBeuf	Calgary
Chris Lord	Edmonton
Elisa Mori-Torres	St. Albert
Giulia Perri	Calgary
Paddy Quail	Calgary
Randall Sargent	Canmore
Jennifer Stickney-Lee	Edmonton
Jean Triscott	Edmonton
Joel Weaver	Lethbridge

APPENDIX 2 Survey Results: Frequency Tables

Table 1: Demographics/Work Settings by Respondents

Characteristics	≤15% Seniors		>15% Seniors		All Respondents	
	n = 54		n = 96		n = 195	
	Number	(%)	Number	(%)	Number	(%)
Gender						
Male	18	(33.3)	46	(47.9)	81	(41.5)
Female	36	(66.7)	49	(51.0)	112	(57.4)
Not Recorded	0	(0.0)	1	(1.0)	2	(1.0)
Age						
≤ 29 yrs	1	(1.9)	2	(2.1)	3	(1.5)
30 – 39 yrs	21	(38.9)	25	(26.0)	59	(30.3)
40 – 49 yrs	15	(27.8)	17	(17.7)	44	(22.6)
50 – 59 yrs	11	(20.4)	37	(38.5)	60	(30.8)
60 – 69 yrs	6	(11.1)	11	(11.5)	24	(12.3)
70+ yrs	0	(0.0)	1	(1.0)	1	(0.5)
Not Recorded	0	(0.0)	3	(3.1)	4	(2.1)
Primary Population Served						
Inner City	5	(9.3)	5	(5.2)	14	(7.2)
Urban/Suburban	32	(59.3)	65	(67.7)	126	(64.6)
Small Town	6	(11.1)	8	(8.3)	20	(10.3)
Rural	8	(14.8)	12	(12.5)	23	(11.8)
Other	2	(3.7)	2	(2.1)	4	(2.1)
Cannot Identify Primary Population	0	(0.0)	3	(3.1)	4	(2.1)
Not Recorded	1	(1.9)	1	(1.0)	4	(2.1)
Current Situations						
Full-time/Part-time Medical Practice	50	(92.6)	86	(89.6)	176	(93.3)
Hospital Appointment	13	(24.1)	22	(22.9)	46	(23.6)
Faculty Appointment	10	(18.5)	17	(17.7)	33	(16.9)
Locum Tenens	3	(5.6)	7	(7.3)	11	(5.6)
Leave of Absence/Sabbatical	1	(1.9)	0	(0.0)	3	(1.5)
Semi-retired	0	(0.0)	3	(3.1)	3	(1.5)
Work Settings						
Private Office/Clinic	45	(83.3)	66	(68.8)	141	(72.3)
Community Hospital	21	(38.9)	42	(43.8)	88	(45.1)
Long Term Care/Assisted Living	9	(16.7)	32	(33.3)	58	(29.1)
Emergency Department	10	(18.5)	24	(25.0)	44	(22.6)
University/Faculty of Medicine	13	(24.1)	21	(21.9)	42	(21.5)

Community Clinic/Community Health Centre	9	(16.7)	13	(13.5)	28	(14.4)
Freestanding Walk-In Clinic	4	(7.4)	9	(9.4)	14	(7.2)
Administrative Office	7	(13.0)	3	(3.1)	10	(5.1)
Other	6	(11.1)	20	(20.8)	30	(15.4)

Characteristics	≤15% Seniors n = 54		>15% Seniors n = 96		All Respondents n = 195	
	Number	(%)	Number	(%)	Number	(%)
Main Patient Care Setting						
Private Office/Clinic	38	(70.4)	57	(59.4)	120	(61.5)
Community Hospital	2	(3.7)	6	(6.3)	16	(8.2)
Emergency Department	2	(3.7)	9	(9.4)	13	(6.7)
Community Clinic/Community Health Centre	2	(3.7)	5	(5.2)	10	(5.1)
University/Faculty of Medicine	2	(3.7)	6	(6.3)	10	(5.1)
Long Term Care/Assisted Living	0	(0.0)	5	(5.2)	7	(3.6)
Freestanding Walk-In Clinic	2	(3.7)	1	(1.0)	3	(1.5)
Other	4	(7.4)	6	(6.3)	11	(5.6)
Do not provide patient care	2	(3.7)	0	(0.0)	2	(1.0)
Not Recorded	0	(0.0)	1	(1.0)	3	(1.5)

APPENDIX 3 Survey Results: Crosstabs by Gender

Table 1.0 Current Working Conditions.

	Male	Female	<i>p</i> -value
Full-Time/Part-Time	96 (93.8%)	100 (88.5%)	0.207
Semi-Retired	3 (3.7%)	0 (0%)	0.039
Locum Tenens	1 (1.2%)	10 (8.8%)	0.024
LOA/Sabbatical	0 (0.0%)	2 (1.0%)	0.229
Faculty Appointment	16 (19.8%)	17 (15%)	0.389
Hospital Appointment	21 (25.9%)	25 (22.1%)	0.539

While locum tenens and semi-retired appear to be statistically significant ($p \leq 0.05$) by gender, the findings should be interpreted with caution given the small sample size in these cells.

Table 2.0 Work Places.

	Male	Female	<i>p</i> -value
Private Office/Clinic	62 (76.5%)	79 (69.9%)	0.307
Community Clinic/CHC	9 (11.1%)	19 (16.8%)	0.265
Walk-in Clinic	6 (7.4%)	8 (7.1%)	0.931
Community Hospital	37 (45.7%)	51 (45.1%)	0.940
Emergency Department	25 (30.9%)	19 (16.8%)	0.021
Long-Term Care	28 (34.6%)	30 (26.5%)	0.229
University	16 (19.8%)	26 (23.0%)	0.587
Administrative Office	5 (6.2%)	5 (4.4%)	0.587

A greater proportion of male family physicians were working in emergency departments.

Table 3.0 Main Patient Care Setting.

	Male	Female
Private Office/Clinic	56 (70%)	64 (58.2%)
Other	24 (30.0%)	46 (41.8%)

$\chi^2=2.78$, $p=0.095$, not significant.

Table 4.0 Primary Patient care Setting Based on Postal Code Data.

	Male	Female
Metropolitan	39 (57.4%)	66 (72.5%)
Regional Areas + Rural	29 (42.6%)	25 (27.5%)

$\chi^2=3.996$, $p \leq 0.046$, statistically significant.

There are a greater proportion of female family physicians in metropolitan settings and more male family physicians in regional/rural settings.

Table 5.0 Primary Population Served by Your Practice.

	Male	Female
Urban/Suburban/Inner City	51 (66.2%)	89 (84.0%)
Small Town/ Rural	29 (33.8%)	25 (16.0%)

$X^2=7.80, p\leq 0.005$, statistically significant.

Greater proportion of female physicians serve urban/suburban/inner city populations and more male physicians in small town/rural.

Note: There is a difference in the significance level (0.046 vs. 0.005) between the tables (postal code region/primary population served). This may be a function of the response rate for each question. There were 159 responses to the postal code question vs. 195 responses to primary population served question.

Table 6.0 Do you see more than 15% seniors in your total patient panel in your practice?

	Male	Female
Yes	22 (71.0%)	41 (74.5%)
No	9 (29.0%)	14 (25.5%)

$X^2=0.130, p=0.719$, not significant.

Table 7.0 Barriers or limitations to overcome before considering taking on more elderly patients in your practice.

	Male	Female
Yes	10 (33.3%)	18 (36.0%)
No	20 (66.7%)	32 (64.0%)

$X^2=0.059, p=0.809$, not significant.

Table 8.0 Age range of respondents to survey.

	Male	Female
29-39 yrs	15 (19.2%)	46 (41.1%)
40-49 yrs	19 (24.4%)	25 (22.3%)
50-59 yrs	27 (34.6%)	33 (29.5%)
60+ yrs	17 (21.8%)	8 (7.1%)

$X^2=14.80, p\leq 0.002$, statistically significant.

Significantly more younger females and more older males responded to this survey.

Table 9.0 Proportion of elderly patients that you seen in your practice.

	Male	Female
15-25%	28 (42.4%)	36 (46.8%)
25-50%	23 (34.8%)	15 (19.5%)
50-75%	9 (13.6%)	12 (15.6%)
>75%	6 (9.1%)	14 (18.2%)

$X^2=5.499, p=0.139$, not significant.

Table 10.0 Change in proportion of elderly patients seen in the last 10 years.

	Male	Female
Increased	61 (95.3%)	62 (95.4%)
Decreased	3 (4.7%)	3 (4.6%)

$X^2=0.0$, $p=0.984$, not significant.

Table 11.0 Places that doctors see elderly patients.

	Male	Female	<i>p</i> -value
Long-term care facilities	36 (44.4%)	35 (31.0%)	0.055
Senior Lodges	18 (22.2%)	19 (16.8%)	0.344
Assisted living settings	17 (21.0%)	16 (14.2%)	0.212
Rehab hosp/Clinics	8 (9.9%)	16 (14.2%)	0.372
Assess/Referral Clinics	3 (3.7%)	11 (9.7%)	0.109
Home Care	10 (12.3%)	13 (11.5%)	0.858
Home Visits	25 (30.9%)	29 (25.7%)	0.425

There appears to be no significant difference in the settings that male and female family physicians see patients.

Table 12.0 Serve in a medical leadership role that supports the elderly.

	Male	Female
Yes	16 (19.8%)	8 (7.1%)
NR/No	65 (80.2%)	105 (92.9%)

$X^2=6.99$, $p\leq 0.008$, statistically significant.

A greater proportion of male family physicians serve in a medical leadership role.

Table 13.0 How satisfied are you with the current FFS as payment for elderly care?

	Male	Female
Satisfied	26 (39.4%)	23 (29.9%)
Not Satisfied	40 (60.6%)	54 (70.1%)

$X^2=1.431$, $p=0.232$, not significant.

Table 14.0 Method of payment.

	Male	Female
Fee-for-Service (FFS)	56 (83.6%)	51 (67.1%)
ARP/Blended ARP +FFS	11 (16.4%)	25 (32.9%)

$X^2=5.13$, $p\leq 0.023$, statistically significant.

A greater proportion of female family physicians appear to be on ARPS, or blended ARP and FFS.

Table 15.0 If you are not on an ARP would you be interested in an ARP for physicians caring for seniors?

	Male	Female
Yes	32 (51.6%)	46 (73.0%)
No	30 (48.4%)	17 (27.0%)

$\chi^2=6.10, p\leq 0.014$, statistically significant.

Significantly more female family physicians are interested in an ARP payment plan.

Table 16.0 Satisfaction with system support to manage elderly.

	Male	Female
Unsatisfied	33 (47.8%)	41 (51.3%)
Neither	16 (23.2%)	16 (20%)
Satisfied	20 (29.0%)	23 (28.8%)

$\chi^2=0.264, p=0.877$, not significant.

Table 17.0 Satisfaction with office support to manage elderly.

	Male	Female
Unsatisfied	31 (45.6%)	31 (39.2%)
Neither	15 (22.1%)	22 (27.8%)
Satisfied	22 (32.4%)	26 (32.9%)

$\chi^2=0.839, p=0.657$, not significant.

Table 18.0 Do you work in a PCN?

	Male	Female
Yes	45 (66.2%)	52 (64.2%)
No	23 (33.8%)	29 (35.8%)

$\chi^2=0.064, p=0.801$, not significant.

Table 19.0 Is the community care system meeting the needs of your patients?

	Male	Female
Yes	18 (26.1%)	17 (22.4%)
No	51 (73.9%)	59 (77.6%)

$\chi^2=0.273, p=0.601$, not significant.

APPENDIX 4 Survey Results: Summary of Comments

In addition to the theme of more facilities, funding, support and remuneration plans that the respondents had previously mentioned, some family physicians took this opportunity to include other creative suggestions. A sample of these suggestions is included.

- *“More Geriatric teams able to do home visits and enable the elderly to remain in their own community. Free taxi vouchers to be used both for visits to a doctor and to maintain contact with social outlets. In cities that have a community league structure, assist the community to have its own seniors activities, immunizations and volunteer supports. Provide payment with subsidized office space and nursing support to physicians who will locate within housing complexes built for the elderly.”*
- *“Encourage or reward families who take the responsibility to care for their aging parents.”*
- *“Consider hiring MDs to care for residents in the long term care facilities as now we have to go to all of them for our patients, consider strategies to keep patients out of the ER when acutely sick, where they can have iv therapy etc on site.”*
- *“Better Home care services. Clinics dedicated to multi-system needs of elderly. Home visit service initiated (for doctors to do house calls regularly).”*
- *“Recognition of the time involved in management of this portion of the population. Help with medication supervision for some so they can remain independent but safe. Adequate nursing homes so that the acute care beds are used more effectively.”*
- *“Lessen my pain, make it worth while, make it easy”*