ACTIVELY BUILDING CAPACITY IN PRIMARY HEALTH CARE

RESEARCH (ABC PROJECT)

Executive Summary of the Reports to

The Ministry of Health and Long-Term Care

Primary Health Care Transition Fund

A Partnership of the

Centre for Studies in Family Medicine of The University of Western Ontario

and the

Ontario College of Family Physicians

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PRIMARY HEALTH CARE PRACTITIONER ENVIRONMENTAL SCAN AND SURVEY

Executive Summary

This summary covers two of the five deliverables of the University of Western Ontario’s components of the Actively Building Capacity (ABC) project for the Primary Health Care Transition Fund. Two of the deliverables were: “to review and collate provider surveys and databases” and “to conduct Phase II surveys to fill in gap in the provider databases”. The first part of this report describes an environmental scan of the provider surveys and databases (Part I). The second part (Part II) reports on the goals, methods, results and future research directions of the survey conducted with the five professions (dietitians, family physicians, pharmacists social workers and nurses) on their activity in primary health care. The mailed survey was sent to 1000 members of each of the five professional groups. Participants were randomly selected from their respective Colleges’ registry stratified by four regions of Ontario using Local Health Integration Networks (north, east, southwest, central). Response rates were acceptable and ranged from 65% to 82%.

Results of the surveys of the five professions in primary health care in Ontario indicated that:

- All five professions were working in the community
- A majority of family physicians, pharmacists and social workers were providing direct community care
- A minority of dietitians and nurses were providing direct community care
We estimated that there were 860 dietitians, 8,800 family physicians, 6,400 pharmacists, 5,541 social workers and 11,000 nurses practicing direct patient care in the community for Ontario. While these were estimates, they were more accurate particularly for dietitians, pharmacists and social workers for which very little data currently exist.

- For the most part community providers were similar to their non-community providers. Demographic characteristics and provider satisfaction scores showed similarities. However, two differences were noteworthy. Family physicians and pharmacists providing care in the community, worked longer hours and saw more patients than their colleagues who worked in hospitals or other institutions. Social workers and nurses working in the community worked more hours but saw fewer patients and dieticians working in the community worked fewer hours and saw fewer patients than their counterparts in hospitals or other institutions.

- While family physicians and pharmacists predominantly worked in their traditional office or business respectively, dietitians, social workers and nurses worked in the broad spectrum of community locations.

- Family physicians and nurses provided services in all primary health care practice areas (women's health, children's health, in-office procedures, chronic disease management, mental health services and medication education); pharmacists provided four types of services (women's health, children’s health, chronic disease
management and medication education); social workers provided a different three types [children's health, in-office procedures (specifically case management services) and mental health services] and dieticians provided predominantly chronic disease management and children’s health.

- All providers reported sharing care with family physicians, nurses and their own profession; family physicians reported working with pharmacists; nurses reported working with social workers.

Therefore, we suggest that family physicians and nurses were the integrators and linchpins of the health care systems. Family physicians and nurses not only provided a wide range of primary health care services compared to the other three provider groups delivering more specialized care, but the other professions reported that family physicians and nurses were collaborating with them in delivering community care. These results emphasize the degree to which informal family health teams exist even in the absence of infrastructure support and formal governance agreements. These naturally evolved community networks need to be respected and, where possible, preserved, in the evolution of any primary health care renewal models.

Many health care professionals currently perceive that they work in a team capacity when providing community-based direct care services to patients. While there are limitations in the data collected, this study provides us with better estimates of who is providing primary care in Ontario and the nature of these professional relationships.
Recommendations for Future Research

Recommendations for future research involve re-examining the provider groups surveyed and the types of questions that would be asked.

**Stage One:** to continue to analyze the current data set to explore sub-analyses for the following relationships:

- What practice characteristics were different between those direct-care community providers who self-identify as primary health care provider compared to those who do not? These data will give us a working definition of the term as used by current practitioners most closely involved with this work. This information will be more useful for planning purposes given the wide variation in existing definitions.

- What are providers’ attitudes and behaviours on working on interdisciplinary primary health care teams and practice patterns?

- How do providers manage after-hours care for their patients?

- How are mental health services provided in primary health care in Ontario?

**Stage Two:** Develop a steering committee of the current provider groups that will revise the current survey to make it more relevant to each profession while maintaining its ability to ask questions on common data elements (e.g., number of hours worked, number of patients/clients seen, practice location, etc.). It may also be that the committee decides to have separate modules for each profession that are more relevant to their provider group’s (e.g., dietitians) work in primary health care. Administer another survey for a second data collection cycle.
Stage Three: Negotiate with the regulatory colleges to have the common data elements (that yield relevant and meaningful data for the Colleges, MOHLTC and agencies required to provide data on primary health care providers [i.e., ICES and CIHI]) to be integrated into their membership renewal forms. If this information was collected, data analyses could be conducted to give an annual report of the state of health human resources issues in primary health care.

Stage Four: To invite other regulated professions and non-regulated professions to create new versions of the survey. One could include these provider groups in future data collection cycles to ensure that a more comprehensive picture of primary health care health human resources issues is developed in future.

THE EXPERIENCE OF TEAMS IN PRIMARY HEALTHCARE

Executive Summary

This study examined the dynamics and characteristics of what makes Primary Health Care Teams (PHCTs) work in Ontario, as well as, the challenges and solutions to teamwork. Furthermore, the study explored the prevention and health promotion strategies used by these PHCTs. This phenomenological qualitative study conducted individual in-depth interviews with a maximum variation sample of 121 participants from 16 PHCTs (10 urban and 6 rural sites). Participants included over a dozen professions (i.e. family physicians, nurses, social workers, pharmacists) across three types of teams: Family Health Groups (FHGs) and Family Health Networks (FHNs); Community Health Centres (CHCs) and; Family Practice Teaching Units (FPTUs). An iterative analysis process conducted by the research team was used to examine the verbatim transcripts.
Three overarching themes emerged from the analyses: 1) what makes a team work - the foundation and pillars of teamwork; 2) challenges faced by primary healthcare teams and; 3) potential solutions and recommendations to help create, build and sustain primary healthcare teams. Analysis of the interviews also provided a "snapshot" of the current prevention and health promotion strategies used by these teams and the community agencies and services most frequently accessed by the study teams.

Participants strongly endorsed a shared philosophy as the foundation of team work. This shared philosophy was two-pronged and included a common vision regarding the provision of patient care (i.e. continuity) as well as a fundamental belief in the value of interprofessional, collaborative team practice, which was reinforced with personalities that “fit together”. Built on this foundation of a shared philosophy were the pillars of trust, respect and communication. These were viewed by participants as the core building blocks of what makes a team work. Embedded within each pillar were specific characteristics. In the pillar of trust were characteristics of relationship building, caring and recognition of scope of practice. Characteristics of reciprocity, feeling valued and working well together reflected the pillar of respect. Within the pillar of communication were characteristics of openness and approachability. Once a solid foundation of a shared philosophy was in place, and the pillars of trust, respect and communication were established, indicators of a well functioning team became evident. Participants from all three types of teams described a wealth of activities, experiences and strategies as indicators of a well functioning team including: job satisfaction; dedication to work; experiencing the team as a family; adaptability to change; environmental tone; strategies to manage stress and conflict; and patient-centred care.
The analysis of the data also revealed both internal and external challenges to teamwork. The four major internal challenges to interprofessional practice included: (1) team composition, roles, and scope of practice, (2) leadership, (3) accountability, and (4) barriers to conflict resolution. The four major external challenges included: (1) health human resources, (2) unrealistic patient expectations, (3) resources and commodities (time, funding, physical work space), and (4) access and wait lists. Key solutions offered by the participants addressed: (1) public education and patient accountability, (2) secure funding mechanisms (3) optimal physical work environments, and (4) methods and means to build and sustain teams specifically team development and team building strategies and mechanisms for communication.

Finally, with regard to prevention and health promotion the analysis of the data revealed a variety of initiatives offered by these teams and the numerous community-based services they utilized.

In summary, what makes a team work is a complex and dynamic interplay of multiple dimensions and reinforcing characteristics. As PHCT teams move towards interprofessional collaborative practice the foundation and pillars of teamwork are paramount in facilitating successful teamwork. The indicators of when a team works well together, as identified in this study, can serve as important variables in the development of evaluation measures to assess interprofessional collaborative teamwork. The internal and external challenges facing PHCTs can be meet by developing creative and innovative solutions. The primary health care climate is ready for change and PHCTs need not be daunted by the challenges before them but rather inspired with various ways to create, build and sustain teams.
Recommendations

These interviews have provided a wealth of information from which we propose seven recommendations. We feel the following recommendations, if enacted, would support and sustain future PHCTs.

1. Develop and disseminate a tool/instrument that would help teams determine/measure whether or not their team is working well;

2. Establish conflict management strategies and protocols;

3. Engage in team-building activities to develop and sustain a collective identity as a team and strengthen a shared philosophy;

4. Encourage and support on-going opportunities for informal and formal communication (i.e. team meetings);

5. Establish leadership that has a clear and defined presence and is recognized by team members as providing direction;

6. Develop a clear understanding and respect for the ways in which each member can contribute to prevention and health promotion and;

7. Provide adequate funding and resources, including appropriate time and space, for health care providers to work in a team environment.
PRIMARY HEALTH CARE PATIENT ACCESS ENVIRONMENTAL SCAN AND SECONDARY DATA ANALYSES OF THE CANADIAN COMMUNITY SURVEY (CCHS 2.1)

Executive Summary

This report covers two of the five deliverables of The University of Western Ontario’s components of the Actively Building Capacity (ABC) Project for the Primary Health Care Transition Fund. These deliverables were to: review patient access surveys in an environmental scan; and, conduct surveys to fill in gaps in access databases. The first part of this report describes the findings of the environmental scan of the review of patient access surveys and databases. The second part reports on the secondary analysis of the Canadian Community Health Survey (CCHS) [2.1] 2003 data to glean profiles of the population with and without access to primary health care.

Two research agencies were in the process of developing primary health care indicators for Ontario and Canada; the Institute for Clinical Evaluative Sciences, and the Canadian Institute of Health Information. Results of these indicators will take time to develop and disseminate. Many relevant variables existed in the Canadian Community Health Surveys (CCHS), however, these need to be analyzed with specific primary health care focus.

Re-analyses of the Canadian Community Health Survey (CCHS) has provided a profile of the prevalence and characteristics of people who lack access to a regular MD in Ontario and the prevalence and the characteristics of those who lack access and who have tried to gain access.
While the CCHS has provided these important data, we noted that the CCHS could not provide data specific to primary medical care or indeed primary health care. This is a recommendation for future research infrastructure, i.e. to provide data on Ontarians who have access or lack access specifically to primary medical care and primary health care.

Further, the Canadian Community Health Survey could not provide universal information on what services had been utilized by the people who had access or did not have access to a regular medical doctor, or indeed those who did not have access and tried or not tried to gain access. It is important in the future to have a profile of the kind of services that are utilized by people who do not perceive they have access to regular medical care.

**Recommendations for Future Research**

We recommend future research infrastructure which will provide information on access to primary medical care, primary health care and when people lack access, to provide universal information on what kind of services medical and allied health professionals are accessed by that population.
REPORT I:

PRIMARY HEALTH CARE PRACTITIONER ENVIRONMENTAL SCAN AND SURVEY
PRIMARY HEALTH CARE PRACTITIONER ENVIRONMENTAL SCAN AND SURVEY

Final Report for Actively Building Capacity in Primary Health Care Research

(ABC Project)

To the Ministry of Health and Long-Term Care
Primary Health Care Transition Fund

A Partnership of the
Centre for Studies in Family Medicine of The University of Western Ontario

and the
Ontario College of Family Physicians

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OVERVIEW

This report covers two of the five deliverables of The University of Western Ontario’s components of the Actively Building Capacity (ABC) project for the Primary Health Care Transition Fund. Two of the deliverables were:

1. “to review and collate provider surveys and databases” and
2. “to conduct Phase II surveys to fill in gap in the provider databases”.

The first part of this report describes an environmental scan of the review of provider surveys and databases (Part I). The second part (Part II) reports on the goals, methods, results and future research directions of the survey conducted with the five professions on their activity in primary health care.

1. PART I: PRIMARY HEALTH CARE PRACTITIONER ENVIRONMENTAL SCAN

1.1. Introduction

The number and type of primary health care providers were unknown in Canada and Ontario when starting this research study. The CIHI 2003 report on Health Care in Canada quantified Canada’s primary health care providers but admitted that the professionals represented in their graph “also provided other levels of care. For example, 60% of registered nurses worked in hospitals in 2001” (p.29). Similarly, in a literature review and environmental scan commissioned by Health Canada, the North South Group (2004) found that most of the information available was on physician and nurse human health resource concerns with other health professional groups receiving “secondary consideration” (p. 47). While
several groups have been studying human health resource issues extensively, who was practicing in primary health care was less clearly defined.

The Actively Building Capacity Project in Primary Health Care Research (ABC Project) being conducted by The University of Western Ontario has reviewed and collated the existing health human resources databases as part of the larger ABC Project managed by the Ontario College of Family Physicians and funded by the Primary Health Care Transition Fund. Part I of this report describes our findings when examining existing databases for information on human health resources issues concerning primary health care.

1.2 Methods

Environmental scans can be an unobtrusive and cost-effective means for policy-makers and researchers to learn what is known and not known by examining the external environment of a given problem (Hatch and Pearson, 1998; Marton, 2001; Weiss et al., 2002). The purpose of an environmental scan is to systematically find and interpret relevant published reports and available data sets on a given topic. Environmental scans employ flexible methodologies and are traditionally intended for government reports that prioritizes timeliness over rigour (Marton, 2001).

Materials examined for this environmental scan were focused on governmental, non-governmental sources and a literature search. We have listed sources used in Appendix 1. Scan techniques from Internet searches, conversations with population health researchers and database experts, were used to identify relevant sources of information. Sources deemed relevant included:
• Original questionnaires and their resultant reports to discover if there were comparable data among professions;

• Data bases and data dictionaries were analyzed to determine if we could develop relevant proxy variables; and,

• Examination of Regulated Health Profession registry data collection procedures and College annual reports.

1.3 Results

There were a multitude of human health resource databases but these did not provide data on primary health care providers with much detail. For example, proxy variables such as the average number health care provider consultations per year could be identified within existing Statistics Canada databases like the National Population Health Survey. While these proxy variables provided useful information on the frequency of health care provider services (see Table 1), they did not provide information under what circumstances or settings these consultations happened or whether they were primary health care services. Provincial databases tend to focus on data collected from billing and service usage data sets (i.e., outpatient services, drug benefit dispensing, nursing home care indicators). Identifying billing codes that were specific to primary health care services (i.e., childhood immunizations) may be a useful way to determine the primary care services of those professions eligible to have OHIP billing numbers, but do not inform us of the services provided by other professions who were not eligible.

Other non-governmental organizations have developed human health resources databases such as the National Physician Survey 2004, The Ontario Physician Human
Resources Data Centre, and the Health Personnel Database from the Canadian Institutes of Health Information (See Table 2). Data sets that were profession-specific described trends within their respective profession. For example, physician databases described trends between physician groups including the differences between family physician and specialist groups or family physicians and general practitioners. The CIHI database included information on the number of professionals registered with their respective regulatory College and the graduation rate from health professional schools. However, some of these data elements are still under development (CIHI, Personal Communication, May 2005).

The Regulated Health Profession Act decrees that each regulatory College shall keep a register of their membership that the public may have access to ensure that only licensed members practice in that profession. We surveyed the annual reports and available online registries to compile the profession membership information available in Table 1. Also, the Colleges usually collected additional data that may determine who was practicing primary health care compared to hospital or institutional care. For example, some may have information whether a member was working in a public health office, a family practice unit, a community clinic, or their profession may have specialized educational programs in primary health care.

However, determining the degree to which a profession was involved in primary health care solely on the data from the Colleges’ registries was not possible at this time. College registry renewal forms did ask the member to provide information on where they are currently practicing, but not all professions collect information on their involvement with primary health care. For example, family physicians were a sub-group of physicians who had specialty training in providing primary health care. However, social workers and dieticians were not
solely identified as health care professionals nor did they have specific sub-specialty training in primary health care. As a result, identifying sub-groups practicing primary health care within these latter professions was more difficult.

1.4 Conclusions

Over the years, numerous agencies have attempted to estimate health human resources, but these were not specific to primary health care. However, this environmental scan has shown that there were no data sources that give comparable data elements across professions that are collected on a consistent basis. The need for systematically collected, Ontario based data on primary health care practitioners was deemed essential to understand the issues in primary health care human health resources policy and planning. Such data were collected and reported in Part II.

2. PART II: PRIMARY HEALTH CARE PRACTITIONER SURVEY

2.1 ABC Practitioner Survey

The ABC provider survey answered two primary health care health human resources questions:

1. What were the proportions of each of the five practitioner groups providing care to patients in a community based setting of those providers, who considered themselves to be a primary health care provider?

2. What were the clinical activities, practice settings and collaborative/shared care activities of these providers?
2.2 Operational Definitions

The definitions for the variables used in this study are described below.

**Primary Health Care**: Primary health care is the foundation of the health care system. When Canadians need health care, most often they turn to front-line or primary health care services – visiting a family physician or nurse practitioner, calling telephone health information lines, seeing mental health workers, or seeking advice from pharmacists. It includes advice on health promotion and disease prevention, health assessments of one’s health, diagnosis and treatment of episodic and chronic conditions, and supportive and rehabilitative care (Schmelzle et al., 2005).

**Areas of Ontario**: Ontario was sub-divided into four areas Metropolitan Central (Central East), West (Central West and Southwest), East (East) and Northern (Northwest and Northeast) based Ontario Ministry of Health planning regions.

**Primary Health Care Practitioners**: The sampling frame of eligible providers was derived from the respective regulatory College data (i.e., Ontario College of Dietitians, Ontario College of Family Physicians, Ontario College of Pharmacists, and Ontario College of Social Workers and Social Service Workers Ontario College of Nurses).

2.3 Survey Mail Out Procedure

A mail-out survey to the five selected primary health care providers in Ontario was chosen because it was deemed to be the most economical and effective way to ascertain providers’ practice of and attitudes towards primary health care. Also, health care professionals were extremely busy and may be more readily reached by mail than interviews.
The methodological weaknesses of surveys were that they may not adequately sample the population of interest, and there was a risk of a low response rate. Therefore, we decided to take advantage of previous research regarding increasing response rates and provided financial incentives and recorded delivery (Thorpe et al., 2005).

2.4 Sampling

The sampling frame of eligible providers was based on procedures recommended from the respective regulatory College for each of the five groups: dietitians, family physicians, pharmacists, social workers and nurses.

1. **Dietitians** – The Ontario College of Dietitians advised us that their register was available from their website. We downloaded this information and randomly sampled 1000 dietitians stratified by the four areas of Ontario.

2. **Family Physicians** – The Ontario College of Family Physicians advised us that a list of family physicians could be obtained from the Canadian Medical Directory (Scott’s Canadian Business Directory and Database, 2004). The sampling frame was obtained in an electronic form from the Canadian Medical Directory (Scott’s Canadian Business Directory and Database, 2004) using physician code 18 that was designated “family physician”. We excluded from the list those business addresses whose postal code was outside of Ontario. Our sample consisted of randomly selecting 1000 family physician participants, stratified by the four areas of Ontario in active practice in all aspects within family practice including emergency room and obstetrics.

3. **Pharmacists** – The Ontario College of Pharmacists recommended that we obtain the electronic version of the Canadian Pharmacists Directory (Scott’s Canadian Business Directory and Database, 2004). We excluded from the sampling frame those
pharmacists whose business addresses were: pharmaceutical companies; government departments; and outside of Ontario. We randomly sampled from this revised sampling frame 1000 pharmacy participants stratified by the four areas of Ontario.

4. Social Workers – The Ontario College of Social Workers received permission from their Board of Directors to release their full registry of social workers. We excluded from the list those business addresses whose postal code was outside of Ontario. We randomly sampled 1000 registered social workers stratified by the four areas of Ontario.

5. Nurses – Working directly with the statistician from the Ontario College of Nurses, we identified sub-groups within the nursing profession who were: in active practice; and broadly defined as working in the community. Examples of these community sub-groups included extended care registration (i.e., nurse practitioners), public health, mental health, visiting nurses and physician office nurses. Once these sub-groups were defined, we randomly sampled this pool of nursing professionals [RN and RN(EC)] stratified by the four areas of Ontario to achieve a sample size of 1000 nursing participants.

2.5 Survey Development

The surveys were developed from an extensive literature search and informal interviews with groups who had previously conducted surveys with primary health care providers. Previous versions of the survey were pre-tested several times on a small, representative sample of health care providers and then revised based on this feedback. The UWO Research Ethics Board approved this study. A copy of this survey is appended in this report (Appendix 3).
2.6 Survey Distribution

The survey was mailed to 5000 primary health care providers, using a modified Dillman method (Dillman, 2000). The surveys along with an incentive gift card and a letter of information were sent via recorded delivery (Thorpe et al., 2005). Approximately ten days later a reminder post card was sent to all participants. Three weeks following the initial mail out, a reminder letter and a second copy of the survey without incentive gift card were mailed to participants who had not yet responded. Every attempt was made to resend surveys that were returned due to an incorrect mailing address to the participant’s corrected address.

2.7 Data Analysis

Descriptive analyses were performed and data was transformed or categorized as appropriate. Bivariate statistical comparisons were carried out using an analysis of variance where appropriate.

2.8 Survey Results

2.8.1 Who Was Registered to Practice in Ontario of the Five Professions?

The number of providers registered to practice in Ontario was obtained on advice from the respective Colleges. After reviewing the computerized list, the business addresses outside of Ontario were removed from the sampling frame. The numbers of practitioners who are currently working in Ontario are seen in Figure 1.
The graph shows that there were a greater number of nurses working in Ontario than the other professions. For example there is a 1 to 10 ratio of pharmacists or social workers. Therefore, it should be noted in subsequent reporting of the results that, while there may be a lower proportion of nurses reporting they practice primary health care, there were still a large number of nurses practicing.

2.8.2 Survey Response Rates

A total of 3373 surveys were returned with analyzable data. After removing those who were ineligible (e.g., retired, died) (69 respondents), refused to participate (109 respondents), and whose address was unknown (312 respondents), the eligible response rates for the five professional groups were the following:

- Dietitians -- 82% (758/921)
- Family Physicians -- 66% (624/950)
• Pharmacists -- 65% (602/921)
• Social Workers -- 77% (722/943)
• Nurses -- 75% (667/884).

These were highly acceptable response rates and add to the internal and external validity of the findings.

Subsequently, 26 surveys were removed due to poor data quality (e.g., missing data made it difficult to determine their status as whether they were working in the community) leaving a total of 3347 surveys in the final data set. The regional stratification of the respondents appeared to be representative of the population of each area (Table 3).

2.8.3 Identification of Direct Care Community Practice Participants

Most primary health care definitions include the aspect of working with patients in health or mental health care in the community and we used these criteria to determine who was eligible to complete the survey. The first questions asked providers to characterize their current practice as “in health care, mental health care or both”. If their current practice was not health or mental care, they were asked to skip to the demographic questions: there were 165 individuals (4.5% of the total number of usable surveys) who identified that they were not currently practicing in health or mental health care. The second question asked those providers who identified if they were currently working in health and/or mental health care to identify all practice settings they currently worked in. There were nine direct-care community provider settings, six institutional settings, and four hospital-based settings. Those who identified working in the community were asked to continue with the next question, while those not working in the community were asked to skip to the demographic questions. There were 790 individuals (24% of the total number of usable surveys) who identified that they were
not working in the community. In total, there were 955 (28.5%) respondents who did not meet the eligibility criteria of currently practicing in health or mental health care and working directly in the community.

2.8.4 Differences Between Those Who Work in the Community Compared to Those Who Work in Institutional or Hospital Settings

Tables 4 and 5 outline the comparisons of those who worked in the direct-care community (DC) versus those who work in institutional or hospital based care (Not DC) on available data. There were no differences between provider groups when examining mean age (range of 42.4 years to 48.6 years) among providers. Dietitians (98%), nursing (96%) and social work (83%) had a greater proportion of females in both community and non-community practice settings. Family physicians and pharmacists showed a greater proportion of women in non-community practices relative to community practices with 62.8% versus 51.1% for pharmacists and 63.6% versus 51.7% for family physicians. Both non-community and community pharmacists and nurses had three to five more in practice compared to other community and non-provider groups: the number of years ranged from 17.2 years for non-community pharmacists to 22.9 years for non-community nurses compared 14.1 years for dietitians to 16.2 years for social workers. There were minimal differences in the number of years worked between non-community and community providers for all provider groups. Almost all provider groups appeared to be satisfied with their current practice with their mean score ranging from 78.6 to 83.1 (1 meaning very unsatisfied with their current practice and 100 meaning very satisfied with their current practice). However, community family physicians’ mean score was five or more points lower that other provider groups at 73.8.
Providers were asked to estimate how many hours they worked at each practice setting as well as the number of patients they saw in a month (Table 5). A two way ANOVA analyzed the factors of provider group, whether the providers worked in the community or not, and the interaction between these two variables on two separate analyses using the dependent variables of “number of hours worked in a month in a professional capacity” and “number of patients seen in a month”. Analyses demonstrated that there was a significant interaction between the professional groups and whether they worked in the community or not for number of hours worked in a month (F = 14.1, df 1,4, p<0.001) and number of patients seen in a month (F = 30.7, df 1, 4, p <0.001). Community family physicians, pharmacists, social workers and nurses worked more hours than their institutional or hospital counter-parts (mean differences of 33.2 hours per month for family physicians and 47.4 hours per month for pharmacists, 45.0 hours for social workers and 12.5 hours for nurses) while there was no difference for dietitians. Direct-care community family physicians and pharmacists saw more patients (mean difference of 298.1 for family physicians and 792.5 for pharmacists) while the other direct-care community provider groups saw fewer patients (mean differences of 48.2 for dietitians, 24.3 for social workers and 87.9 for nurses) than their colleagues in institutional or hospital settings. These results indicated that were substantial differences in the workload distribution between those practitioners who work in the community compared with other settings. However, because of different provider practice patterns, these relationships need to be explored in more detail to understand the meaning of these differences. Data from Table 5, showing the number of hours worked in community, institutional and hospital settings, indicated that community care providers also work in institutional and hospital settings and, therefore, were working in multiple settings.
2.8.5 Focusing of Direct-Care Community Practitioners

The percentage of respondents who identified working directly with patients in the community is illustrated in the left hand bar for each provider group in Figure 2. All subsequent results will focus on the direct-care community providers. Eligible respondents were asked the following question, “Do you feel that you provide primary health care?” Percentages of these respondents are shown in the right hand bar for each provider group in Figure 2.

Figure 2: Direct Care Community Providers and Self-Described PHC Providers (%)

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1 Because the sampling frames where developed in a slightly different manner for the pharmacists and nurses, the calculations for both sets of bars were different than the other three provider groups. With the pharmacists, those working in the industry or government were excluded from the random selection procedure. With the nurses, we had access to individual level, registry data for only those nurses who were to receive surveys. Therefore, because we were dealing with a sub-sample of the total Ontario college registry data for these two professions, we multiplied the ratio of survey participants responding to the question of interest by the ratio of registry members in the sampling frame by the total number of Ontario registry members. Calculations were the following: (Question X respondents/number of usable surveys) * (number of registry members used sampling frame/number of registry members in Ontario) * 100.
There were high proportions of family physicians, pharmacists and social workers working directly with patients in the community but there were smaller proportions of dietitians and nurses. Family physicians were most likely to identify themselves as primary health care providers while pharmacists, dietitians and social workers were moderately likely, and nurses were least likely to identify working as primary health care providers.

2.8.6 Type of Patient Environment for Direct Care Community Practitioners

As is seen in Table 6, four of the practitioner groups identified that they were solely health care providers but not solely mental health care providers. Conversely, social workers were more likely to identify themselves as sole mental health providers. However, except dietitians, greater than 20% of the four profession groups identified that they were working as both health and mental health care providers with pharmacists at the lower end of the range at 20.3% and family physicians at the highest end of the range at 39.7%. The majority of the providers surveyed spend two-thirds or more of their working hours in the community with dietitians spending the lowest amount of time at 74.2% and pharmacists spending the most amount at 94.5% of their time (Table 7).

The percentage of respondents who were able to work with patients in a language other than English is shown in Table 8. One quarter of the respondents (minimum 18.5% for social workers to a maximum of 33.1 for family physicians) practiced in a language other than English. Approximately 11.8% of practitioners were able to provide services in French and approximately 16.4% provided services in another language other than English or French. The most common languages provided included in declining order were Chinese and Cantonese, Italian, Hindi and Punjabi, as well as Arabic and Farsi.
2.8.7 Where Do Direct Care, Community Practitioners Work?

The providers were asked to indicate where they worked in the community from nine, broadly defined settings that included; physicians’ office/family practice unit; community care access centres; public health unit of department; community health centres; retail business; social service agency or community mental health programs; clinical private practice or consulting; schools, colleges or universities; nursing or staffing agencies; and visiting nursing agencies. As Figure 3 demonstrates, the majority of family physicians work in physician offices and the majority of pharmacists worked in retail business. The other three professions tend to work across the spectrum of community practices. The majority of dietitians worked in CHC, CCAC’s and private practice; social workers worked in social service agencies, private practice and at schools; and, nurses work at nursing agencies, as visiting nurses or in public health units (Table 9).
2.8.8 What Services Do the Direct-Care Community-Based Professions Provide?

Respondents were asked to indicate, from six broad areas of primary health care practice, which of the specific services or activities they provided to their patients. These broad areas included women’s health, children’s health, in-office procedures, chronic disease management, mental health services, and medication education and adherence. (For the specific services, see question three of the survey in Appendix 3.) Providers were then dichotomized into two groups; those who provided three or fewer services as the low involvement group; and, those who provided four or more services as the high involvement group. All professions except social work reported high involvement in chronic disease management. As seen in Figure 4, a high proportion of family physicians showed high involvement in all of these six broad areas of service ranging from 61.5% for children’s health to 93.6% for chronic disease management. A high percentage of nurses also showed a high
involvement in chronic disease management and low involvement in five of the remaining broad areas of service. A high percentage of dietitians reported a high involvement with chronic disease management and a low involvement with children’s health.

Pharmacists showed high involvement in medication education and assessment and chronic disease management and a low involvement in in-office procedures and women’s health. Social workers showed high involvement in mental health services and a low involvement in children’s health and in-office procedures. These findings were not surprising for pharmacists and social workers given that these were the professions’ respective areas of specialization. Case management and advocacy was an activity provided by 48.7% of social workers and included as an in-office procedure. All of the professions were providing some level of services or activities across the six broad areas of primary health care (Table 10).

Figure 4: What Practice Areas and Number Services Do They Provide?

<table>
<thead>
<tr>
<th></th>
<th>Diet</th>
<th>FP</th>
<th>Pharm</th>
<th>SW</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Women’s Health</strong></td>
<td>★★★</td>
<td>★</td>
<td></td>
<td></td>
<td>★</td>
</tr>
<tr>
<td><strong>Children’s Health</strong></td>
<td>★</td>
<td>★★</td>
<td></td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td><strong>In-office Procedure</strong></td>
<td>★★★</td>
<td>★</td>
<td></td>
<td>★</td>
<td>★</td>
</tr>
<tr>
<td><strong>Chronic Disease Management</strong></td>
<td>★★★</td>
<td>★★</td>
<td>★★★</td>
<td></td>
<td>★★★</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td>★★</td>
<td></td>
<td>★★★</td>
<td></td>
<td>★</td>
</tr>
<tr>
<td><strong>Medication Education and Assessment</strong></td>
<td>★★</td>
<td>★★</td>
<td></td>
<td></td>
<td>★</td>
</tr>
</tbody>
</table>

★★★★ = ≥ 4 services by ≥40% of providers  
★★  = ≤ 3 services by ≥30% of providers
2.8.9 With Whom Do They Share Patient Care in Their Office or Unit?

Respondents were asked to identify “with whom do you share patient and/or client care within your community patient/client care setting (that is, your office or unit)” (Table 11). Very few respondents (<9%) reported not sharing their office or unit with another provider. The highest or second highest percentage reported by each profession is sharing care with members of their own profession. All professions reported working with family physicians as one of the highest three professions they shared care with (>53% for all providers). All professions reported working with RN/RPN as one of their highest three professions they work with (>35% for all professions).

Figure 5: Who Do They Share Patient Care Within Your Office/Unit?
2.9 Discussion and Conclusions

2.9.1 Numbers of Practitioners Practicing in the Community

One of the goals of this study was to estimate the numbers of the providers using the terms “direct patient care” in “the community” as an operational definition and/or proxy for primary health care. Combining the data obtained from the College registries with the survey data\(^2\), we can make these approximations more clearly than those appearing in previous reports noted in the environmental scan (CIHI, 2003). We estimated that there were 860 dietitians, 8,800 family physicians, 6,400 pharmacists, 5,541 social workers and 11,000 nurses practicing direct patient care in the community for Ontario. While these were estimates, they were more accurate particularly for dieticians, pharmacists and social workers for which very little data currently exist.

2.9.2 Profile of Practitioners Working in the Community

To what extent were PHC providers who gave direct patient care in the community the same or different from their professional colleagues who worked elsewhere (e.g. in hospitals or other institutions)? For the most part community providers were similar. Three demographic characteristics and provider satisfaction scores showed similarities. However, two differences were noteworthy. Family physicians and pharmacists providing care in the community, worked longer hours and saw many more patients than their colleagues who worked in hospitals or other institutions. Social workers and nurses working in the community worked more hours but saw fewer patients and dieticians working in the community worked fewer hours and saw fewer patients than their counterparts in hospitals or other institutions.

\(^2\)These estimates were created by multiplying the percentages shown in Figure 2 (left hand bar for each profession) by the appropriate estimate of the total number of professionals on their respective College registry prorated according to the different sampling strategies for each profession/provider group.
2.9.3 Where were Community Practitioners Working?

While family physicians worked mostly in their office settings and pharmacists worked mostly in their retail business setting, dieticians, social workers and nurses worked in a variety of settings, sometimes even individual practitioners having a number of workplaces. This may reflect different role functions within these three professions, some more relevant perhaps to public health than primary care but included in these surveys nonetheless.

2.9.4 Types of Services Provided by Community Health Professions

The results indicated the high level of comprehensive care were provided by family physicians and nurses in the community; these two professions provided all six types and five of the six types, respectively, of care listed in the survey. We suggest therefore that family physicians and nurses are the integrators and linchpins of the health care systems. The other provider groups provided slightly more specialized care with dietitians reporting a focus on chronic disease management.

2.9.5 Sharing Care

A stunning finding of these surveys was the extent that these five provider groups shared patient care in their practice setting. To be expected, they shared care with their own profession. But more interesting was that all professions worked with family physicians and nurses as well. This can be construed as an additional way in which family physicians and nurses were integrators ("linchpin"); they not only provided a wide range of services, but the other professions reported that family physicians and nurses were collaborating with them in delivering community care. These results emphasize the degree to which informal family health teams exist even in the absence of infrastructure support and formal governance
agreements. These naturally evolved community networks need to be respected and, where possible, preserved, in the evolution of any primary health care renewal models.

There was some worry in professional colleges that the new models of PHC would lead to an advantaged group of patients who receive new models of care and a disadvantaged group whose providers would not work in teams. The findings of this study indicated that, even without the formal structures of PHC renewal, providers currently collaborated in the care of their patients. In conclusion, there seem to be virtual teams at work in community care in Ontario.

2.10 Strengths of the Study

The unique contribution of this study was including five key provider groups involved in community primary care. While family physicians and nurses (not necessarily community nurses though) have been surveyed in the past, dieticians, pharmacists and social workers have not.

A second strength of the study was that its design permitted direct comparison among the five provider groups because identical questionnaire items were used throughout. A third strength was the survey distribution methods that ensured a high response rate.

2.11 Limitations of the Study

The surveys may not have adequately captured the practice patterns of dietitians. There were: relatively few dietitians compared to other primary health care provider groups; they spend less time working in direct-care community settings compared to other providers; and a lower percentage of dietitians had a lower involvement in five of the six broad areas of primary health care. We had many phone calls from dietitians who felt that they were providing
primary health care but were having difficulty completing the survey because they did not work directly with patients but advised other providers on creating programming or that they worked directly with patients but in small local hospitals.

The surveys were sent to family physicians that were designated as such in the Canadian Medical Directory and did not survey those whom were registered as general practitioners. Since there are no clear estimates regarding which general practitioners were providing services in family medicine, we elected not to include this group in our survey at this time. There are other data sources that provided an excellent summary of the differences between these groups available through the National Physician Survey (National Physician Survey, 2004). We caution the reader that our estimates of family physician involvement in primary health care may overestimate their involvement and that estimates of the absolute numbers of physicians involved in primary health care may be inaccurate because of the problem of varying counts, as shown in the footnote.

There were other professions we could have surveyed but did not do so. This was in part due to a MOHLTC request that we focus on the five providers groups included in this report. We were also attempting to make the data collection process more manageable given that the original end date of the Primary Health Care Transition Fund Projects was March 31, 2006. However, the dataset would be more representative of the providers in primary health care if we had included other provider groups such as physiotherapy, occupational therapy, midwifery, psychology, and chiropractic.

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3 There are several data sources providing an estimate of the number of FP/GPs that were working in family medicine at the time of writing this report. These included those who were registered as family physicians in published in the Canadian Medical Directory (n = 4485); from the Ontario Physicians Human Resources Database (9842 in family practice); and the Ontario College of Family Physicians combined their voluntary membership list with OHIP billing data (n ~6500 in family practice). The Ministry of Health and Long-Term Care has identified 8600 comprehensive family physicians (defined by billing patterns); a further 2000 have focused practices (e.g. psychotherapy) (May 17, 2006 Jim McLean, MOHLTC Lead on Primary Health Care).
On a similar note, the study would have also been more representative if we had included those providers who are not registered with their respective College or non-registered professions. Not all social workers or social service workers were registered with the College of Social Work and Social Services Workers since their registration is recommended but voluntary. Also, many provider groups such as personal service workers were highly involved in primary health care but did not have a regulatory body.

2.12 Recommendations for Future Research

Recommendations for future research involve re-examining the provider groups surveyed and the types of questions that would be asked.

- **Stage One**: to continue to analyze the current data set to explore sub-analyses for the following relationships:
  
  - What practice characteristics were different between those direct-care community providers who self-identify as primary health care provider compared to those who do not? These data will give us a working definition of the term as used by current practitioners most closely involved with this work. This information will be more useful for planning purposes given the wide variation in existing definitions.
  
  - What are providers’ attitudes and behaviours on working on interdisciplinary primary health care teams and practice patterns?
  
  - How do providers manage after-hours care for their patients?
  
  - How are mental health services provided in primary health care in Ontario?
• **Stage Two:** Develop a steering committee of the current provider groups that will revise the current survey to make it more relevant to each profession while maintaining its ability to ask questions on common data elements (e.g., number of hours worked, number of patients/clients seen, practice location, etc.). It may also be that the committee decides to have separate modules for each profession that are more relevant to their provider group’s (e.g., dietitians) work in primary health care. Administer another survey for a second data collection cycle.

• **Stage Three:** Negotiate with the regulatory colleges to have the common data elements (that yield relevant and meaningful data for the Colleges, MOHLTC and agencies required to provide data on primary health care providers [i.e., ICES and CIHI]) to be integrated into their membership renewal forms. If this information was collected, data analyses could be conducted to give an annual report of the state of health human resources issues in primary health care.

• **Stage Four:** To invite other regulated professions and non-regulated professions to create new versions of the survey. One could include these provider groups in future data collection cycles to ensure that a more comprehensive picture of primary health care health human resources issues is developed in future.
REFERENCES


Canadian Institutes of Health Information. Personal Communication, May 2005.


North South Group, Inc. (2004) Literature review and environmental scan of preferred practices for deployment of health human resources and decision support tools: Final


http://www.hfrp.org
APPENDIX 1: SOURCES FOR THE PRIMARY HEALTH CARE PRACTITIONER

ENVIRONMENTAL SCAN

National/Local Surveys


Canadian Institute for Health Information (CIHI). CIHI **Health Indicator Check List for Health Indicators** (2004) URL>>[http://www.cihi.ca/hirpt.jsp/HIDispatcher.jsp](http://www.cihi.ca/hirpt.jsp/HIDispatcher.jsp)


URL>> [www3.who.int/whosis/health_personnel/health_personnel.cfm](http://www3.who.int/whosis/health_personnel/health_personnel.cfm)

*Profession-Based Surveys*

URL>> [http://www.cno.org/about/stats/report.htm](http://www.cno.org/about/stats/report.htm)


URL>> [http://www.health.gov.on.ca/english/providers/providers/providers_mn.html](http://www.health.gov.on.ca/english/providers/providers/providers_mn.html)

Thames Valley Family Practice Research Unit (TVFPRU) and SouthWestern Ontario Medical Education Network (SWOMEN) **Family Physician and Specialists Questionnaires- Unpublished Data**

The Ontario Physician Human Resources Data Centre (OPHRDC). **1.0 Active Physicians in ONTARIO by Specialty of Practice and Planning Region in 2002** (2003)  
URL>> [https://www.ophrdc.org/PublicPagesPIO/OverviewAboutPIO.aspx?MenuID=100](https://www.ophrdc.org/PublicPagesPIO/OverviewAboutPIO.aspx?MenuID=100)

URL>> [http://cfpc.ca/nps/English/home.asp](http://cfpc.ca/nps/English/home.asp)
College Registry Data

URL >> [http://www.cdo.on.ca/](http://www.cdo.on.ca/)
**Access to Registry:** [https://members.cdo.on.ca/source/members/publicregister.cfm](https://members.cdo.on.ca/source/members/publicregister.cfm)


**Access to Registry:** [http://www.cno.org/about/stats/report.htm](http://www.cno.org/about/stats/report.htm)


Ontario College of Pharmacists.  **Directory of Pharmacists** (2001)

URL >> [http://www.cpso.on.ca/](http://www.cpso.on.ca/)

URL >> [http://www.ocswssw.org](http://www.ocswssw.org)
**Access to Registry:** [http://www.ocswssw.org/sections/membership_info/registration.html](http://www.ocswssw.org/sections/membership_info/registration.html)

### APPENDIX 2: TABLES FOR PRACTITIONER ENVIRONMENTAL SCAN AND SURVEY RESULTS

#### Table 1: Number of Health Care Practitioners in Ontario

<table>
<thead>
<tr>
<th>Health Care Professional</th>
<th>Total Number of Health Care Professionals in Ontario as Per College Information‡</th>
<th>Total Number of Inactive Health Care Professionals‡</th>
<th>Total Number of Active Health Care Practitioners‡</th>
<th>Average Number of Consultations*</th>
<th>Standard Deviation of Number of Consultations*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Physicians</strong></td>
<td>22819</td>
<td>7144</td>
<td>15675</td>
<td>3.47</td>
<td>4.58</td>
</tr>
<tr>
<td><strong>Occupational Therapist</strong></td>
<td>3889</td>
<td>--</td>
<td>--</td>
<td>0.08</td>
<td>0.81</td>
</tr>
<tr>
<td><strong>Physiotherapist</strong></td>
<td>6188</td>
<td>--</td>
<td>--</td>
<td>0.59</td>
<td>3.42</td>
</tr>
<tr>
<td><strong>Midwives</strong></td>
<td>--</td>
<td>249</td>
<td>3020</td>
<td>0.94</td>
<td>4.13</td>
</tr>
<tr>
<td><strong>Chiropractors</strong></td>
<td>3303</td>
<td>283</td>
<td>3020</td>
<td>1.05</td>
<td>0.21</td>
</tr>
<tr>
<td><strong>Psychologists</strong></td>
<td>2714</td>
<td>--</td>
<td>--</td>
<td>0.07</td>
<td>0.75</td>
</tr>
<tr>
<td><strong>Social Workers/Social Service Workers</strong></td>
<td>10440</td>
<td>534</td>
<td>9906</td>
<td>0.2</td>
<td>1.32</td>
</tr>
<tr>
<td><strong>Social Workers</strong></td>
<td>--</td>
<td>397</td>
<td>9072</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacists</strong></td>
<td>~12000</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Dieticians</strong></td>
<td>2473</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Nurses</strong></td>
<td>136244</td>
<td>19120</td>
<td>117124</td>
<td>0.24</td>
<td>1.35</td>
</tr>
<tr>
<td><strong>Registered Nurses (General)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Registered Nurses (Extended)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Registered Practical Nurses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*‡ These data are collected from the respective College websites – either from their online registry data or from available reports. For the most part, they represent the College registrar information collected in 2004.  
* National Population Health Survey  
-- Selected individual sample from 1998
### Table 2: Examples of Existing Health Care Provider Databases

<table>
<thead>
<tr>
<th>Mission/Goal</th>
<th>Data Collection (Cycle)</th>
<th>Unit of Analyses</th>
<th>Information Available</th>
<th>Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulated Health Professions Act, 1991</td>
<td>To maintain public access registry of all members of each College</td>
<td>Ongoing but at a minimum annually</td>
<td>Individual member</td>
<td>Name, business address and phone, place of employment/access to practice, class of registration and specialist status</td>
</tr>
<tr>
<td>CIHI Health Human Resource Databases (Canadian Institute for Health Information)</td>
<td>Collect, process and analyse summary data on the number of health care professionals in Canada from over 300 professions</td>
<td>Ongoing</td>
<td>Aggregate, supply-based counts by province/territory and year selected</td>
<td>Number of members of each professional associations by province and year; active status and graduation rates where available</td>
</tr>
<tr>
<td>OPHRDC (The Ontario Physician Human Resources Data Centre)</td>
<td>To maintain an up to date list of all practicing physicians in Ontario</td>
<td>Approximately 20% of Ontario physicians surveyed each year by phone</td>
<td>Individual physician</td>
<td>Type of specialty, area of practice, age and gender</td>
</tr>
</tbody>
</table>
Table 3: Percentage of Respondents by MOHLTC Area

<table>
<thead>
<tr>
<th>(% in each area)</th>
<th>Dietitians (n=747)</th>
<th>Family Practitioners (n=621)</th>
<th>Pharmacists (n=599)</th>
<th>Social Workers (n=719)</th>
<th>Nurses (n=661)</th>
<th>Total (n = 3347)</th>
</tr>
</thead>
<tbody>
<tr>
<td>East (LHIN 10–11)</td>
<td>12.7</td>
<td>11.6</td>
<td>8.1</td>
<td>8.1</td>
<td>9.9</td>
<td>10.1</td>
</tr>
<tr>
<td>Central (LHIN 5–9)</td>
<td>40.5</td>
<td>44.4</td>
<td>45.3</td>
<td>43.7</td>
<td>39.0</td>
<td>42.5</td>
</tr>
<tr>
<td>North (LHIN 12–14)</td>
<td>13.0</td>
<td>11.8</td>
<td>13.7</td>
<td>13.5</td>
<td>12.2</td>
<td>12.8</td>
</tr>
<tr>
<td>West (LHIN 1–4)</td>
<td>33.8</td>
<td>32.1</td>
<td>32.9</td>
<td>34.7</td>
<td>39.0</td>
<td>34.6</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
### Table 4: Years in Practice, Year of Birth, Gender, and Satisfaction with Current Practice by Community and Non-Community

<table>
<thead>
<tr>
<th></th>
<th>Dietitians (n=747)</th>
<th>Family Practitioners (n=621)</th>
<th>Pharmacists (n=599)</th>
<th>Social Workers (n=719)</th>
<th>Nurses (n=661)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(SD: Standard Deviation)</strong></td>
<td>Not DC n=459</td>
<td>DC n=288</td>
<td>Not DC n=43</td>
<td>DC n=578</td>
<td>Not DC n=270</td>
</tr>
<tr>
<td>Percentage Females in Profession</td>
<td>98.7</td>
<td>98.3</td>
<td>62.8</td>
<td>51.1</td>
<td>82.3</td>
</tr>
<tr>
<td>Current Age Mean/ SD</td>
<td>42.4 (9.5)</td>
<td>42.4 (9.5)</td>
<td>44.0 (10.2)</td>
<td>45.4 (9.0)</td>
<td>43.8 (9.5)</td>
</tr>
<tr>
<td>Years in Practice Mean/ SD</td>
<td>14.8 (9.3)</td>
<td>14.1 (9.3)</td>
<td>14.6 (10.6)</td>
<td>15.2 (9.7)</td>
<td>14.8 (9.0)</td>
</tr>
<tr>
<td>Satisfaction with practice Mean/ SD</td>
<td>79.9 (15.5)</td>
<td>79.2 (16.6)</td>
<td>77.8 (17.1)</td>
<td>73.8 (17.8)</td>
<td>80.7 (16.7)</td>
</tr>
</tbody>
</table>

- **DC = direct care community provider**
- Percentages have been calculated by using the percent of sub-samples of Not DC vs. DC’s
Table 5: Hours Worked Per Month in All Settings and Number of Patients Seen per Month by Community and Non-Community

<table>
<thead>
<tr>
<th>(SD: Standard Deviation)</th>
<th>Dietitians (n=747)</th>
<th>Family Practitioners (n=621)</th>
<th>Pharmacists (n=599)</th>
<th>Social Workers (n=719)</th>
<th>Nurses (n=661)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not DC n=459</td>
<td>DC n=288</td>
<td>Not DC n=70</td>
<td>DC n=529</td>
<td>Not DC n=270</td>
<td>DC n=449</td>
</tr>
<tr>
<td>Hours per month working in a professional capacity overall Mean/ (SD)</td>
<td>124.1 (60.2)</td>
<td>127.8 (72.0)</td>
<td>103.7 (70.5)</td>
<td>86.6 (98.0)</td>
<td>123.5 (57.4)</td>
</tr>
<tr>
<td></td>
<td>125.6 (44.3)</td>
<td>161.0 (59.7)</td>
<td>151.1 (66.0)</td>
<td>131.5 (49.7)</td>
<td>136.0 (48.9)</td>
</tr>
<tr>
<td>Hours per month working in a Community Based Care Setting Mean/ (SD)</td>
<td>0.0 (0.0)</td>
<td>0.0 (0.0)</td>
<td>0.0 (0.0)</td>
<td>0.0 (0.0)</td>
<td>0.0 (0.0)</td>
</tr>
<tr>
<td></td>
<td>94.7 (55.2)</td>
<td>138.6 (56.6)</td>
<td>143.0 (67.8)</td>
<td>122.3 (50.6)</td>
<td>128.9 (45.0)</td>
</tr>
<tr>
<td>Hours per month working in an Institutional Setting Mean/ (SD)</td>
<td>31.4 (58.3)</td>
<td>11.6 (33.3)</td>
<td>20.9 (56.3)</td>
<td>12.3 (40.2)</td>
<td>45.3 (72.3)</td>
</tr>
<tr>
<td></td>
<td>17.8 (45.1)</td>
<td>5.6 (18.7)</td>
<td>4.0 (20.6)</td>
<td>1.5 (14.6)</td>
<td>1.9 (13.6)</td>
</tr>
<tr>
<td>Hours per month working in a Hospital Setting Mean/ (SD)</td>
<td>92.5 (74.7)</td>
<td>19.3 (44.7)</td>
<td>82.7 (72.7)</td>
<td>74.3 (98.7)</td>
<td>78.3 (70.5)</td>
</tr>
<tr>
<td></td>
<td>110.0 (77.6)</td>
<td>16.7 (35.4)</td>
<td>4.1 (23.8)</td>
<td>7.9 (32.9)</td>
<td>5.0 (23.4)</td>
</tr>
<tr>
<td>Number of Patients usually seen in a month? Mean/ (SD)</td>
<td>155.2 (130.5)</td>
<td>106.9 (110.6)</td>
<td>260.8 (360.2)</td>
<td>96.4 (102.4)</td>
<td>289.6 (309.7)</td>
</tr>
<tr>
<td></td>
<td>233.4 (193.0)</td>
<td>531.5 (241.3)</td>
<td>1053.4 (1071.4)</td>
<td>72.1 (76.1)</td>
<td>201.6 (296.1)</td>
</tr>
</tbody>
</table>

- **DC** = direct care community provider
- Percentages have been calculated by using the percent of sub-samples of Not DC vs. DC’s
### Table 6: Health, Mental Health Service Provision for Direct Care Community Providers

<table>
<thead>
<tr>
<th>% Direct Care Community Practitioners</th>
<th>Dietitians n = 287</th>
<th>Family Physicians n = 577</th>
<th>Pharmacists n = 528</th>
<th>Social Workers n = 449</th>
<th>Nurses n = 551</th>
<th>Total Providers n = 2392</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care</td>
<td>92.3</td>
<td>60.3</td>
<td>79.7</td>
<td>12.5</td>
<td>69.0</td>
<td>61.5</td>
</tr>
<tr>
<td>Mental Health Care</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>58.6</td>
<td>2.0</td>
<td>11.5</td>
</tr>
<tr>
<td>Both Health And Mental Care</td>
<td>7.7</td>
<td>39.7</td>
<td>20.3</td>
<td>29.0</td>
<td>29.0</td>
<td>27.1</td>
</tr>
<tr>
<td>Total Percentage</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Table 7: Percentage of Hours Worked per Month by Direct Care Community Providers

<table>
<thead>
<tr>
<th>% of Hours Worked per month</th>
<th>Dietitians n = 287</th>
<th>Family Physicians n = 577</th>
<th>Pharmacists n = 528</th>
<th>Social Workers n = 449</th>
<th>Nurses n = 551</th>
<th>Total Providers n = 2392</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 32%</td>
<td>19.5</td>
<td>3.6</td>
<td>3.8</td>
<td>4.0</td>
<td>1.6</td>
<td>5.2</td>
</tr>
<tr>
<td>33 to 66%</td>
<td>6.3</td>
<td>9.7</td>
<td>1.7</td>
<td>3.3</td>
<td>3.8</td>
<td>5.0</td>
</tr>
<tr>
<td>≥67%</td>
<td>74.2</td>
<td>86.7</td>
<td>94.5</td>
<td>92.7</td>
<td>94.6</td>
<td>89.8</td>
</tr>
<tr>
<td>Total Percentage</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
### Table 8: Percentage of Direct Care Community Respondents Who Currently Practice in a Language Other Than English

<table>
<thead>
<tr>
<th>% Direct Care Community Practitioners</th>
<th>Dietitian n = 287</th>
<th>Family Physician n = 577</th>
<th>Pharmacist n = 528</th>
<th>Social Work n = 449</th>
<th>Nurse n = 551</th>
<th>Total n = 2392</th>
</tr>
</thead>
<tbody>
<tr>
<td>French</td>
<td>13.2</td>
<td>15.1</td>
<td>11.2</td>
<td>10.2</td>
<td>9.4</td>
<td>11.8</td>
</tr>
<tr>
<td>Other</td>
<td>10.8</td>
<td>22.4</td>
<td>25.4</td>
<td>9.6</td>
<td>10.0</td>
<td>16.4</td>
</tr>
<tr>
<td>Total practice in another language</td>
<td>22.6</td>
<td>33.1</td>
<td>32.8</td>
<td>18.5</td>
<td>18.7</td>
<td>25.7</td>
</tr>
</tbody>
</table>

* Total number of respondents does not equal the percentage of respondents who practiced in French or another language since some respondents may practiced in both French and another language.
Table 9: What Community Based Setting Do They Work in by Profession for Direct Care Community Providers?

<table>
<thead>
<tr>
<th>% Direct Care Community Practitioners</th>
<th>Dietitians n = 287</th>
<th>Family Physicians n = 577</th>
<th>Pharmacists n = 528</th>
<th>Social Workers n = 449</th>
<th>Nurses n = 551</th>
<th>Total Providers n = 2392</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent Can work in more than one setting</td>
<td>Physician’s Office</td>
<td>11.8</td>
<td>93.1</td>
<td>1.5</td>
<td>1.8</td>
<td>17.1</td>
</tr>
<tr>
<td></td>
<td>CHC</td>
<td>20.2</td>
<td>4.2</td>
<td>1.7</td>
<td>5.3</td>
<td>9.8</td>
</tr>
<tr>
<td></td>
<td>Public Health</td>
<td>30.3</td>
<td>2.6</td>
<td>0.2</td>
<td>1.6</td>
<td>35.6</td>
</tr>
<tr>
<td></td>
<td>CCAC</td>
<td>11.5</td>
<td>1.2</td>
<td>0.8</td>
<td>6.9</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td>Retail Business</td>
<td>1.7</td>
<td>0.0</td>
<td>97.7</td>
<td>0.2</td>
<td>0.7</td>
</tr>
<tr>
<td></td>
<td>Social Service Agency</td>
<td>1.4</td>
<td>2.1</td>
<td>0.4</td>
<td>48.6</td>
<td>15.1</td>
</tr>
<tr>
<td></td>
<td>Private Practice/Consulting</td>
<td>26.1</td>
<td>4.0</td>
<td>2.1</td>
<td>28.1</td>
<td>1.8</td>
</tr>
<tr>
<td></td>
<td>School</td>
<td>9.1</td>
<td>4.3</td>
<td>3.8</td>
<td>15.1</td>
<td>4.7</td>
</tr>
<tr>
<td></td>
<td>Visiting Nursing, Nursing Staffing Agency</td>
<td>1.4</td>
<td>0.3</td>
<td>0.8</td>
<td>0.2</td>
<td>26.3</td>
</tr>
</tbody>
</table>
### Table 10: What Types of Services Do They Provide by Direct Care Community Providers?

<table>
<thead>
<tr>
<th>% of Direct Care Community Providers</th>
<th>Dietitians n = 287</th>
<th>Family Physicians n = 577</th>
<th>Pharmacists n = 528</th>
<th>Social Workers n = 449</th>
<th>Nurses n = 551</th>
<th>Total Providers n = 2392</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s Health</td>
<td>&lt; 3</td>
<td>25.8</td>
<td>1.6</td>
<td>41.7</td>
<td>28.5</td>
<td>22.1</td>
</tr>
<tr>
<td></td>
<td>≥ 4</td>
<td>0.3</td>
<td>93.6</td>
<td>14.0</td>
<td>2.9</td>
<td>25.0</td>
</tr>
<tr>
<td>Children’s Health</td>
<td>&lt; 3</td>
<td>29.3</td>
<td>29.8</td>
<td>22.2</td>
<td>43.2</td>
<td>25.6</td>
</tr>
<tr>
<td></td>
<td>≥ 4</td>
<td>0.3</td>
<td>61.5</td>
<td>0.9</td>
<td>2.4</td>
<td>17.4</td>
</tr>
<tr>
<td>In-office procedure</td>
<td>&lt; 3</td>
<td>25.1</td>
<td>2.8</td>
<td>32.4</td>
<td>48.7</td>
<td>45.9</td>
</tr>
<tr>
<td></td>
<td>≥ 4</td>
<td>0.3</td>
<td>93.2</td>
<td>12.7</td>
<td>0.2</td>
<td>23.0</td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td>&lt; 3</td>
<td>28.2</td>
<td>2.8</td>
<td>16.7</td>
<td>9.4</td>
<td>15.2</td>
</tr>
<tr>
<td></td>
<td>≥ 4</td>
<td>45.3</td>
<td>93.6</td>
<td>55.5</td>
<td>2.0</td>
<td>40.5</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>&lt; 3</td>
<td>24.7</td>
<td>23.2</td>
<td>17.4</td>
<td>33.4</td>
<td>29.8</td>
</tr>
<tr>
<td></td>
<td>≥ 4</td>
<td>0.7</td>
<td>66.0</td>
<td>3.2</td>
<td>56.3</td>
<td>21.4</td>
</tr>
<tr>
<td>Medication Education and Assessment</td>
<td>&lt; 3</td>
<td>7.7</td>
<td>10.7</td>
<td>2.8</td>
<td>6.0</td>
<td>31.9</td>
</tr>
<tr>
<td></td>
<td>≥ 4</td>
<td>0.7</td>
<td>85.1</td>
<td>94.1</td>
<td>0.7</td>
<td>26.0</td>
</tr>
</tbody>
</table>
Table 11: Who Do They Share Patient Care Within Your Office or Unit By Direct Care Community Providers?

<table>
<thead>
<tr>
<th>% Direct Care Community Practitioners</th>
<th>Dietitians report working with… n = 287</th>
<th>Family Physicians report working with… n = 577</th>
<th>Pharmacists report working with… n = 528</th>
<th>Social Workers report working with… n = 449</th>
<th>Nurses report working with… n = 551</th>
<th>Total Providers report working with… n = 2392</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietitian</td>
<td>65.2</td>
<td>35.7</td>
<td>18.8</td>
<td>15.1</td>
<td>46.5</td>
<td>34.1</td>
</tr>
<tr>
<td>Family Physicians</td>
<td>58.2</td>
<td>81.8</td>
<td>85.6</td>
<td>53.5</td>
<td>74.4</td>
<td>72.8</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>20.6</td>
<td>43.7</td>
<td>81.1</td>
<td>11.1</td>
<td>41.0</td>
<td>42.4</td>
</tr>
<tr>
<td>Social Workers</td>
<td>39.0</td>
<td>34.1</td>
<td>22.5</td>
<td>83.5</td>
<td>51.4</td>
<td>45.4</td>
</tr>
<tr>
<td>Nurses</td>
<td>72.1</td>
<td>59.6</td>
<td>58.7</td>
<td>35.2</td>
<td>84.4</td>
<td>62.0</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>38.7</td>
<td>22.9</td>
<td>56.8</td>
<td>22.7</td>
<td>36.8</td>
<td>35.2</td>
</tr>
</tbody>
</table>
APPENDIX 3: ABC PRACTITIONER SURVEY
PRIMARY HEALTH CARE PRACTITIONERS’ QUESTIONNAIRE

Would you please take a few moments to answer some questions about your experiences in Primary Health Care? The Actively Building Capacity in Primary Health Care Research Project from the Centre for Studies in Family Medicine at The University of Western Ontario is conducting this survey to determine who is practicing primary health care in Ontario and to obtain practice profiles of primary health care providers.

The information you are sharing will be used to help the Ministry of Health and Long-Term Care implement future policies and programs in primary health care renewal. The data will be shared within the Ministry, professional colleges and universities, at academic conferences and in academic publications. Please be assured your responses will be kept confidential. Your answers will not be reported individually but will be reported in a grouped format.

Please note that the survey can be completed in about 15 minutes or less.

Survey pages may stick together, so please turn them carefully.

Thank you for taking the time to complete this questionnaire. Your answers are important to us.

These first questions are attempting to determine what type of care provider you are.

1. (a) Would you characterize your current professional practice as working in “health care”?
   
   Yes 1  No 0

   (b) Would you characterize your current professional practice as working in “mental health care”?
   
   Yes 1  No 0

   If you responded “Yes” to either Question 1(a) or 1(b), please continue to Question 2

   If you responded “No” to both Question 1(a) and 1(b), please move to Question 16 (Demographic Information)
2. **Do you work in any of the following HEALTH CARE or MENTAL HEALTH CARE settings?**

We are asking this question of many different health care providers across Ontario. We know that some of the following practice setting definitions overlap or may not apply to your profession.

We are interested in knowing which settings **most closely represent where you currently practice**. (Please quickly read the bolded headings first, then check all that apply including the number of hours per month you work in that setting. The list of practice settings starts on this page and finishes on page 4).

<table>
<thead>
<tr>
<th>Community Based Care Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1 (a) Physician’s Office/Family Practice Unit</strong></td>
</tr>
<tr>
<td>▪ Group or solo practice of physicians providing primary care.</td>
</tr>
<tr>
<td>▪ For example, a Doctor’s Office, Family Health Network, Walk-in Clinic, Urgent Care Centre</td>
</tr>
<tr>
<td>(b) If checked Physician’s Office/Family Practice Unit, how is the practice organized? <em>(Please check only one)</em></td>
</tr>
<tr>
<td>□ Solo 1</td>
</tr>
<tr>
<td>□ Family physician group practice 2</td>
</tr>
<tr>
<td>□ Family physician/specialist group practice 3</td>
</tr>
<tr>
<td>(c) If checked Physician’s Office/ Family Practice Unit, the physicians’ office is a: <em>(Please check ALL that apply)</em></td>
</tr>
<tr>
<td>□ Family Health Team (FHT)? 1</td>
</tr>
<tr>
<td>□ Family Health Network (FHN)? 2</td>
</tr>
<tr>
<td>□ Family Health Group (FHG)? 3</td>
</tr>
<tr>
<td>□ Free standing Walk-in-Clinic 4</td>
</tr>
<tr>
<td>□ Health Services Organization (HSO)? 5</td>
</tr>
<tr>
<td>□ Other, Please specify 6 ________________________?</td>
</tr>
<tr>
<td><strong>1.2 Social Service Agency/Community Mental Health Programs</strong></td>
</tr>
<tr>
<td>▪ Community program serving people with mental health and/or addiction problems</td>
</tr>
<tr>
<td>▪ Programs typically non-profit organizations with some funding from the Ministry of Community and Social Services</td>
</tr>
<tr>
<td>▪ Examples include the Canadian Mental Health Association, Schizophrenia Society of Ontario, Assertive Community Treatment Team, Children’s Aid Society, Family Services Agency</td>
</tr>
<tr>
<td><strong>1.3 Community Health Centres</strong></td>
</tr>
<tr>
<td>▪ Not-for-profit, community-governed organizations providing primary health care, health promotion and community development services</td>
</tr>
<tr>
<td>▪ Typically using multi-disciplinary teams of health providers</td>
</tr>
<tr>
<td><strong>1.4 Retail Business</strong></td>
</tr>
<tr>
<td>▪ For example, Pharmacy, Nutrition Centre, Assistive Devices, Cafeteria, Grocery Store</td>
</tr>
<tr>
<td>Community Based Care Setting (cont’d)</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>1.5 Public Health Unit/Department</strong></td>
</tr>
<tr>
<td>• Official health agency established by a group of urban and</td>
</tr>
<tr>
<td>rural municipalities to provide a more efficient community</td>
</tr>
<tr>
<td>health programs, carried out by full-time, specially</td>
</tr>
<tr>
<td>qualified staff.</td>
</tr>
<tr>
<td><strong>1.6 Clinical Private Practice and/or Consulting:</strong></td>
</tr>
<tr>
<td><em>Please specify:</em></td>
</tr>
<tr>
<td><strong>1.7 Schools/Colleges/Universities</strong></td>
</tr>
<tr>
<td>• The elementary and secondary schools (public and private),</td>
</tr>
<tr>
<td>• Colleges of Applied Arts and Technology,</td>
</tr>
<tr>
<td>• Universities and privately funded degree-granting institutions</td>
</tr>
<tr>
<td><strong>1.8 Community Care Access Centres</strong></td>
</tr>
<tr>
<td>• Community organizations providing a simplified point of</td>
</tr>
<tr>
<td>access to long-term care and community services</td>
</tr>
<tr>
<td>• For example, Home Care Programs</td>
</tr>
<tr>
<td><strong>1.9 Nursing/Staffing Agencies</strong></td>
</tr>
<tr>
<td>• Companies providing nursing services to fill in shifts in</td>
</tr>
<tr>
<td>community agencies, hospitals and facilities</td>
</tr>
<tr>
<td>• For example, Nursing Registry, Private Duty Agency</td>
</tr>
<tr>
<td><strong>1.10 Visiting Nursing Agency</strong></td>
</tr>
<tr>
<td>• Agency providing nursing services supporting individuals</td>
</tr>
<tr>
<td>to remain in their homes</td>
</tr>
<tr>
<td>• Services provided primarily in home but also in other</td>
</tr>
<tr>
<td>settings like schools</td>
</tr>
<tr>
<td>• For example, Victorian Order of Nurses, St. Elizabeth</td>
</tr>
<tr>
<td>Health Care, Comcare, Para-Med</td>
</tr>
<tr>
<td><strong>1.11 Other Community Settings</strong></td>
</tr>
<tr>
<td><em>Please specify:</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Care Setting</th>
<th>Question 2 Continued</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.1 Government/Association/Regulatory/Union</strong></td>
<td></td>
</tr>
<tr>
<td>• Provincial and federal governments</td>
<td></td>
</tr>
<tr>
<td>• Organizations and associations involved in supporting</td>
<td></td>
</tr>
<tr>
<td>professions and charged with regulating health professions</td>
<td></td>
</tr>
<tr>
<td>recognized under the Regulated Health Professions Act.</td>
<td></td>
</tr>
<tr>
<td>• For example, Federal and Provincial Ministries, College of</td>
<td></td>
</tr>
<tr>
<td>Nurses of Ontario, Local Health Integration Networks,</td>
<td></td>
</tr>
<tr>
<td>Heart &amp; Stroke Foundation</td>
<td></td>
</tr>
<tr>
<td><strong>2.2 Industry</strong></td>
<td></td>
</tr>
<tr>
<td>• Commercial or industrial enterprise involved in the</td>
<td></td>
</tr>
<tr>
<td>production, manufacturing or processing of goods and/or</td>
<td></td>
</tr>
<tr>
<td>services</td>
<td></td>
</tr>
<tr>
<td>• For example: Food, Agricultural, Pharmaceutical, Insurance</td>
<td></td>
</tr>
<tr>
<td><strong>2.3 Research</strong></td>
<td></td>
</tr>
<tr>
<td>• For example, University, CIHI, Pharmaceutical Company,</td>
<td></td>
</tr>
<tr>
<td>Research Consulting Business</td>
<td></td>
</tr>
</tbody>
</table>
## Secondary Care Setting (cont’d)

<table>
<thead>
<tr>
<th>Question 2 Continued</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4 <strong>Long-Term Care Facility</strong></td>
</tr>
<tr>
<td>- Facilities for people who are not able to live independently and who require 24-hour nursing service to be available to meet their nursing and personal care needs</td>
</tr>
<tr>
<td>- For example, Long-term Care Centre, Nursing Home, Home for the Aged</td>
</tr>
<tr>
<td>□  hrs/ month</td>
</tr>
<tr>
<td>2.5 <strong>Retirement Home</strong></td>
</tr>
<tr>
<td>- Residential complex occupied by 10 or more persons primarily 65 years of age or older</td>
</tr>
<tr>
<td>- Receiving care services, whether or not receiving the services is the primary purpose of the occupancy</td>
</tr>
<tr>
<td>- (Care Home, Rest Home, Lodge, Manor, Assisted Living)</td>
</tr>
<tr>
<td>□  hrs/ month</td>
</tr>
<tr>
<td>2.6 <strong>Other Secondary Care Setting:</strong></td>
</tr>
<tr>
<td><em>Please specify:</em> ___________________________</td>
</tr>
<tr>
<td>□  hrs/ month</td>
</tr>
</tbody>
</table>

## Tertiary Care Setting

<table>
<thead>
<tr>
<th>Question 2 Continued</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 <strong>Acute Care Hospital</strong></td>
</tr>
<tr>
<td>- Medical, surgical, nursing and allied health professionals providing rapid, intensive interventions</td>
</tr>
<tr>
<td>□  hrs/ month</td>
</tr>
<tr>
<td>3.2 <strong>Addiction and Mental Health Centre/Psychiatric Hospital</strong></td>
</tr>
<tr>
<td>- Specializes in treating persons with mental health and/or addiction problems</td>
</tr>
<tr>
<td>□  hrs/ month</td>
</tr>
<tr>
<td>3.3 <strong>Complex Continuing Care/Rehabilitation Hospital</strong></td>
</tr>
<tr>
<td>- Complex Continuing Care Hospital provides 24-hour nursing care for a chronic or serious illness</td>
</tr>
<tr>
<td>- Rehabilitation Hospital provides assessment and treatment for conditions expected to improve significantly through physical medicine and rehabilitative services</td>
</tr>
<tr>
<td>□  hrs/ month</td>
</tr>
<tr>
<td>3.4 <strong>Other Hospital</strong></td>
</tr>
<tr>
<td>- Any other hospital excluding those mentioned above</td>
</tr>
<tr>
<td>- For example, Children’s Treatment Centres, Private Hospitals (excluding unemployment), Federal Hospitals, Cancer Care Ontario</td>
</tr>
<tr>
<td>□  hrs/ month</td>
</tr>
</tbody>
</table>

## Do you work in another setting not previously mentioned? Question 2 Continued

<table>
<thead>
<tr>
<th>Question 2 Continued</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 <strong>Other</strong></td>
</tr>
<tr>
<td><em>Please specify:</em> ___________________________</td>
</tr>
<tr>
<td>□  hrs/ month</td>
</tr>
<tr>
<td>4.2 <strong>Not Currently Employed</strong></td>
</tr>
<tr>
<td>□</td>
</tr>
</tbody>
</table>

### End of Question Two

If you answered “YES” to any Community Based Care Settings (1.1 to 1.11), please continue with Question 3.

If you answered “YES” to Secondary, Tertiary, or Other Care Settings (2.1 to 4.1), please go to the Demographic Section starting with Question 16.
3. (a) Thinking about your practice OVERALL, which of the following patient or client care activities do you provide? (Please check ALL that apply)

<table>
<thead>
<tr>
<th>Women’s Health</th>
<th>Chronic Disease Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Family Planning/Contraceptive Care 10</td>
<td>□ Allergy Desensitization 40</td>
</tr>
<tr>
<td>□ Prenatal Care 11</td>
<td>□ Pain Management 41</td>
</tr>
<tr>
<td>□ Sexual Assault/Family Violence 12</td>
<td>□ Palliative Care 42</td>
</tr>
<tr>
<td>□ Pap Smears 13</td>
<td>□ Obesity/Weight Loss 43</td>
</tr>
<tr>
<td>□ Mammography Referral 14</td>
<td>□ Asthma/COPD 44</td>
</tr>
<tr>
<td>□ Pregnancy Counselling 15</td>
<td>□ Blood Glucose Monitoring 45</td>
</tr>
<tr>
<td>□ STD Counselling 16</td>
<td>□ Blood Pressure Monitoring 46</td>
</tr>
<tr>
<td>□ STD Screening 17</td>
<td>□ Gastro-Intestinal Disease/Food Allergies 47</td>
</tr>
<tr>
<td>□ Breast Self-Examination 18</td>
<td>□ Cardiovascular Disease 48</td>
</tr>
<tr>
<td></td>
<td>□ Diabetes Care 49</td>
</tr>
<tr>
<td>Children’s Health</td>
<td>Mental Health Services</td>
</tr>
<tr>
<td>□ Psychotherapy Counselling-Children 20</td>
<td>□ Addiction Care/Counselling 50</td>
</tr>
<tr>
<td>□ Play Therapy 21</td>
<td>□ Family Assessment and Counselling 51</td>
</tr>
<tr>
<td>□ Childhood Immunizations 22</td>
<td>□ Psychotherapy/Counselling-Adults 52</td>
</tr>
<tr>
<td>□ Parenting Programs 23</td>
<td>□ Caregiver Support 53</td>
</tr>
<tr>
<td>□ Prenatal Nutrition Programs 24</td>
<td>□ Suicide Prevention 54</td>
</tr>
<tr>
<td>□ Breast Feeding Assistance 25</td>
<td>□ Mood Disorder Clinics and Therapies 55</td>
</tr>
<tr>
<td>□ Screening for Developmental Delays 26</td>
<td>□ Crisis Counselling 56</td>
</tr>
<tr>
<td>□ Screening for Learning Disabilities 27</td>
<td>□ Bereavement Counselling 57</td>
</tr>
<tr>
<td>□ Well Baby Examination 28</td>
<td>□ Eating Disorders Care 58</td>
</tr>
<tr>
<td></td>
<td>□ Obsessive Compulsive Disorder Care 59</td>
</tr>
<tr>
<td>Other Care</td>
<td>Medication Education and Adherence</td>
</tr>
<tr>
<td>□ Case Coordination and Advocacy 30</td>
<td>□ Prescription Drug Counselling 60</td>
</tr>
<tr>
<td>□ Acute Episodic Care (Minor Illness) 31</td>
<td>□ Over-the-Counter Medication Counselling 61</td>
</tr>
<tr>
<td>□ Surgery – Excisions/I &amp; D/Suturing 32</td>
<td>□ Alternative Medicine Counselling 62</td>
</tr>
<tr>
<td>□ Procedures (Dressings, Ear Syringing) 33</td>
<td>□ Blister Packaging 63</td>
</tr>
<tr>
<td>□ Travel Health Care 34</td>
<td>□ Older Person Medication Assessments 64</td>
</tr>
<tr>
<td>□ Influenza Immunizations 35</td>
<td>□ Dispense Prescription Medications 65</td>
</tr>
<tr>
<td>□ PSA Tests 36</td>
<td>□ Morning-After Pills 66</td>
</tr>
<tr>
<td>□ Fecal Occult Blood 37</td>
<td>□ Prescribe Medications 67</td>
</tr>
<tr>
<td>□ Osteoporosis 38</td>
<td>□ Needle Exchange Program 68</td>
</tr>
<tr>
<td>□ Infectious Disease 39</td>
<td>□ Smoking Cessation Interventions 69</td>
</tr>
</tbody>
</table>

(b) Are there other patient/client services you provide that we have not previously mentioned? List here:
________________________________________________________________________
________________________________________________________________________

RI-51
4. (a) Do you provide professional consultation services to other professionals as part of your regular practice?

   Yes 1  No 0

   → If no, go to question 5

   (b) Do these consultation services include: (Please check ALL that apply)

   - Informal meetings (e.g., hallways, coffee time, phone calls)? 1
   - Reviewing the patient chart for advice to the referring practitioner? 2
   - Meeting with the patient directly? 3
   - Attending case-consultation meetings with other practitioners? 4
   - Providing formal education sessions to other practitioners? 5
   - Other? 6 Please specify: ____________________________

5. Indicate the types of practitioners with whom you share patient and/or client care within your community-based patient/client care setting (that is, your office or unit). (Please check ALL that apply)

   - Family physicians (including residents) 1
   - Nurse practitioners 2
   - Nurses (e.g. RN, LPN, RPN) 3
   - Medical and/or lab assistants 4
   - Technicians/Technologists 5
   - Pharmacists 6
   - Dietitians 7
   - Specialist physicians 8
   - Social workers 9
   - Psychologists 10
   - Physiotherapists 11
   - Case workers 12
   - Occupational therapists 13
   - Midwives 14
   - Other, Please specify 15

6. Indicate the types of administrative staff with whom you work at your community-based patient/client care setting. (Please check ALL that apply)

   - Receptionists 1
   - Administrative Assistants 2
   - Administrators/Practice Managers 3
   - Secretaries 4
   - Accountant 5
   - Billing Clerk 6
   - Computer Support Personnel 7
   - Other, Please specify 8

7. How do new patients and/or clients come to your practice setting? (Please check ALL that apply)

   - Not accepting new patients/clients 1
   - Walk Ins 2
   - Advertisements from Yellow Pages 3
   - Referral from other patient/client 4
   - Referral from insurance company 5
   - Referral from another community–based agency 6
   - Referral from a hospital based clinic 7
   - Self-refers 8
   - Advertisement from community distributed flyers 9
   - Must be referred by their family physician 10
   - Court ordered treatment 11
   - Referral from a medical specialist 12
   - Referral from a nurse 13
   - Other 14 Please specify ____________________________
8. (a) Does your practice setting have a waiting-list for patients/clients to receive services or to be added on the office roster? *(Please circle only one)*

Yes 1  No 0  
→ If no, go to question 9

(b) If yes, how many patients/clients are on your waiting list or to be added on the office roster?

__________ patients/clients on our waiting list

(c) If yes, how many days would it take for a patient to receive service or to be added on the office roster?

__________ day(s) to receive service

9. (a) Do you ever refer your patients/clients to other practitioners?

Yes 1  No 0  (If no, go to Question 10.)

(b) If yes, how do you refer your patients/clients to any of the following practitioners? *(Please circle only one referral procedure that applies to each health care practitioner listed in the far left hand column.)*

<table>
<thead>
<tr>
<th>Health Care Practitioner</th>
<th>Works outside my team: Patient given information to contact directly</th>
<th>Works outside my team: Referral procedure, phone call, fax or letter</th>
<th>Do not refer to them</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Family Physicians</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>b) Specialist Physicians</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>c) Nurse Practitioners</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>d) Nurses</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>e) Dietitians</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>f) Psychologists</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>g) Occupational Therapists</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>h) Physiotherapists</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>i) Social Workers</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>j) Case Workers</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>k) Pharmacists</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>l) Medical and/or Lab Assistants</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>m) Technicians</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>o) Midwives</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>p) Other, <em>Please specify</em></td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
10. When you are away (i.e., extended illness or vacation), who covers your practice? (Please check only one)

☐ No one covers for me 0
☐ Additional Staff are brought in (i.e., Locum or Relief Staff) 1
☐ Other team members cover for me as part of their regular duties 2
☐ I belong to a sign out or call group 3

11. Where do you advise your patients/clients to go first for emergent care after business hours (evenings and weekends)? (Please check only one)

☐ I carry a pager and return their calls 1
☐ Advise them to go to a Walk-in Clinic 4
☐ I return their calls in the morning 3
☐ My practice is an after-hours care service (e.g., Telehealth Ontario, Walk-in Clinic, etc.) 0
☐ I share call with a group of practitioners 2
☐ Advise them to go to Emergency Department 5
☐ My practice setting hired staff to cover after hours service 6
☐ Advise them to call Telehealth or Telehealth advisory service 7
☐ Other 8 (Please specify): ______________________

12. How are you compensated for your professional services? (Please check ALL that apply)

**Self-employment income:**

☐ Core funding from the Ministry of Health and Long-term Care 1
☐ Core funding from a not-for-profit source 2
☐ Core-funding from the Ministry of Community and Social Services 3
☐ OHIP billing 4
☐ Core funding from a for-profit source 5
☐ Patient Payments 6
☐ Patient Insurance Payments 7
☐ Other payment (Please specify) 8:

**Employment income:**

☐ Full-time, permanent employee with my practice setting 9
☐ Part-time, permanent employee with my practice setting (s) 10
☐ Full time, contract employee with my practice setting 11
☐ Part-time, contract employee with my practice setting (s) 12
☐ On-call with one practice setting (nurses on call) 13
☐ On-call with more than one practice setting 14
☐ Other payment 15 (Please specify): ______________________
13. Did you complete specialized training in primary health care? (*Please check only one*)

- Yes, family medicine practice residency
- Yes, Education Placement/Internship in a Family Practice Unit (Academic or Community)
- Yes, Other (*Please specify*): 
- Yes, Pharmacy Doctorate specializing in Primary Care
- Yes, Primary Care Nurse Practitioner Program
- No

14. Do you feel that you provide primary health care? (*Please circle only one*)

- No
- Yes
- Not sure

If “No”, please skip to Question 16

If “Yes” or “Not sure”, please continue with Question 15

15. You may or may not work in an interdisciplinary primary health care team. But, we are interested in your opinions about the real or potential advantages and disadvantages that interdisciplinary primary health care teams provide. How strongly do you feel that interdisciplinary primary health care teams may or may not help you in the following areas? (*Please circle the response that best matches your opinion*)

<table>
<thead>
<tr>
<th>Working in an interdisciplinary primary health care team would ............</th>
<th>Very strongly agree</th>
<th>Strongly agree</th>
<th>Somewhat agree</th>
<th>Somewhat disagree</th>
<th>Very strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) allow me to focus/specialize on practice areas that I excel at</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>b) be difficult to achieve because of financial compensation amongst the practitioners and staff</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>c) increase the number of health professionals entering into primary health care</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>d) have other practitioners sharing in the day to day management issues of a practice and/or business</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>e) improve health care services in my community</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>f) not suit my working style</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>g) help managing my patient/client load</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>h) improve care for patients with more complex mental health</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Working in an interdisciplinary primary health care team would ..........</td>
<td>Very strongly agree</td>
<td>Strongly agree</td>
<td>Somewhat agree</td>
<td>Somewhat disagree</td>
<td>Very strongly disagree</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>-------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>i) increase the amount of on-call work I do</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>j) improve care for patients with more complex dietary needs</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>k) reduce the number of patients going to walk-in clinics and emergency departments</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>l) help me know more about what other professions can do for my patients/clients</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>m) help me learn more about better care for my patients/clients by having regular communication with other health professionals</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>n) be difficult to achieve because of professional autonomy, liability and staff supervision issues</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>o) make me feel more supported as a practitioner</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>p) improve care for patients with more complex medication needs</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

**Demographic Section**

16. How many hours per month do you work in a **professional capacity**? (For your reference, the number of hours worked in a month for a regular business week is 140 at 7 hrs/day over 20 days)

__________ hours per month in a professional capacity

17. What is the usual number of patients and/or clients seen in month? (For your reference, you would see 560 patients per month if seeing 4 patients an hour at 7 hours per day over 20 days.)

__________ number of patients and/or clients seen in a month

18. Please describe the area in which you practice. **(Please check the description that best suits the area you practice in)**

   - [ ] Inner city 1
   - [ ] Urban 2
   - [ ] Suburban 3
   - [ ] Small town 4
   - [ ] Rural 5
   - [ ] Geographically isolated / remote 6
19. Please indicate the languages in which you are able to provide primary health care services: *(Please check ALL that apply)*

- [ ] French 1
- [ ] English 0
- [ ] Other: *(Please specify):* __________________________

20. In which **county** do you do the majority of your practice? *(Please check only one)*

<table>
<thead>
<tr>
<th>County, Regional or District Municipality</th>
<th>Durham 11</th>
<th>□</th>
<th>Toronto 15</th>
<th>□</th>
<th>Toronto Metropolitan 51</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central East</td>
<td>Haliburton 12</td>
<td>□</td>
<td>East 16</td>
<td>□</td>
<td>Frontenac 61</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Northumberland 13</td>
<td>□</td>
<td>Hastings Lanark 62</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peterborough Simcoe 14</td>
<td>□</td>
<td>Leeds &amp; Grenville 63</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Victoria 15</td>
<td>□</td>
<td>Lennox &amp; Addington Ottawa-Carleton 64</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>York 16</td>
<td>□</td>
<td>Prescott &amp; Russell 65</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central South</td>
<td>Brant 21</td>
<td>□</td>
<td>Prince Edward 66</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Haldimand-Norfolk 22</td>
<td>□</td>
<td>Renfrew 67</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hamilton-Wentworth 23</td>
<td>□</td>
<td>Stormont Dundas &amp; Glengarry 68</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Niagara 24</td>
<td>□</td>
<td>North 71</td>
<td>□</td>
<td></td>
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21. Are you currently a: *(Please check only one)*

- [ ] Family Physician / General Practitioner 1
- [ ] Family Physician/ Emergency Physician 2
- [ ] Dietitian 3
- [ ] Nurse (RN) 4
- [ ] Nurse Practitioner (RN EC) 5
- [ ] Nurse (RPN) 6
- [ ] Pharmacist 7
- [ ] Social Worker (RSW) 8
- [ ] Social Worker (Not Registered) 9
- [ ] Other: 10 __________________________
22. In terms of practicing your profession are you currently: (Please check only one)

☐ Active (Full or Part-time) 1  ☐ Temporarily inactive (not practicing in province, sick or paternal leave, etc.) 2

☐ Permanently inactive (retired, etc.) 3  ☐ Other (Please specify) 4 ______________________________

23. What is your current highest educational degree? (Please check only one)

☐ MD 1  ☐ BScN 2  ☐ BA 3

☐ BSW 4  ☐ MSW 5  ☐ BSc 6

☐ BSc (Pharm) 7  ☐ Pharm D 8  ☐ MSc (Pharm) 9

☐ MSc (Nursing) 10  ☐ PhD 11  ☐ Other 12 Please Specify: ______________________________

24. How many years have you been in practice? __________ year(s) in a professional practice

25. What is your year of birth? I was born in ________________

26. What is your gender?

Male 1  Female 0

27. Overall, how satisfied are you with your practice? (Please circle the response that best matches your opinion)

1  2  3  4  5  6  7  8  9  10

Very Unsatisfied  Unsatisfied  Fairly Unsatisfied  Fairly Satisfied  Satisfied  Very Satisfied

28. Are you interested in receiving a report about this study when it is completed?

Yes 1  No 0

If yes, please give us your current e-mail address so that we can send you the World Wide Web link to the report when available. This e-mail address will only be used to send you final report information.
29. We welcome any additional comments you may have on primary health care, this survey or any other comments.

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Thank you very much for completing this questionnaire.

Once completed, please return it to us in the envelope provided or to:

Centre for Studies in Family Medicine,
The University of Western Ontario,
UWO Research Park,
1151 Richmond Street,
London, ON, N6A 9Z9
REPORT II:

THE EXPERIENCE OF TEAMS IN PRIMARY HEALTHCARE
REPORT II

THE EXPERIENCE OF TEAMS IN PRIMARY HEALTHCARE:

Final Report for Actively Building Capacity in Primary Health Care Research
(ABC Project)

The Ministry of Health and Long-Term Care

Primary Health Care Transition Fund

A Partnership of the

Centre for Studies in Family Medicine of The University of Western Ontario

and the

Ontario College of Family Physicians

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July 31st, 2006
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EXECUTIVE SUMMARY

This study examined the dynamics and characteristics of what makes Primary Health Care Teams (PHCTs) work in Ontario, as well as, the challenges and solutions to teamwork. Furthermore, the study explored the prevention and health promotion strategies used by these PHCTs. This phenomenological qualitative study conducted individual in-depth interviews with a maximum variation sample of 121 participants from 16 PHCTs (10 urban and 6 rural sites). Participants included over a dozen professions (i.e. family physicians, nurses, social workers, pharmacists) across three types of teams: Family Health Groups (FHGs) and Family Health Networks (FHNs); Community Health Centres (CHCs) and; Family Practice Teaching Units (FPTUs). An iterative analysis process conducted by the research team was used to examine the verbatim transcripts.

Three overarching themes emerged from the analyses: 1) what makes a team work - the foundation and pillars of teamwork; 2) challenges faced by primary healthcare teams and; 3) potential solutions and recommendations to help create, build and sustain primary healthcare teams. Analysis of the interviews also provided a "snapshot" of the current prevention and health promotion strategies used by these teams and the community agencies and services most frequently accessed by the study teams.

Participants strongly endorsed a shared philosophy as the foundation of team work. This shared philosophy was two-pronged and included a common vision regarding the provision of patient care (i.e. continuity) as well as a fundamental belief in the value of interprofessional, collaborative team practice, which was reinforced with personalities that “fit together”. Built on this foundation of a shared philosophy were the pillars of trust,
respect and communication. These were viewed by participants as the core building blocks of what makes a team work. Embedded within each pillar were specific characteristics. In the pillar of trust were characteristics of relationship building, caring and recognition of scope of practice. Characteristics of reciprocity, feeling valued and working well together reflected the pillar of respect. Within the pillar of communication were characteristics of openness and approachability. Once a solid foundation of a shared philosophy was in place, and the pillars of trust, respect and communication were established, indicators of a well functioning team became evident. Participants from all three types of teams described a wealth of activities, experiences and strategies as indicators of a well functioning team including: job satisfaction; dedication to work; experiencing the team as a family; adaptability to change; environmental tone; strategies to manage stress and conflict; and patient-centred care.

The analysis of the data also revealed both internal and external challenges to teamwork. The four major internal challenges to interprofessional practice included: (1) team composition, roles, and scope of practice, (2) leadership, (3) accountability, and (4) barriers to conflict resolution. The four major external challenges included: (1) health human resources, (2) unrealistic patient expectations, (3) resources and commodities (time, funding, physical work space), and (4) access and wait lists. Key solutions offered by the participants addressed: (1) public education and patient accountability, (2) secure funding mechanisms (3) optimal physical work environments, and (4) methods and means to build and sustain teams specifically team development and team building strategies and mechanisms for communication.
Finally, with regard to prevention and health promotion the analysis of the data revealed a variety of initiatives offered by these teams and the numerous community-based services they utilized.

In summary, what makes a team work is a complex and dynamic interplay of multiple dimensions and reinforcing characteristics. As PHCT teams move towards interprofessional collaborative practice the foundation and pillars of teamwork are paramount in facilitating successful teamwork. The indicators of when a team works well together, as identified in this study, can serve as important variables in the development of evaluation measures to assess interprofessional collaborative teamwork. The internal and external challenges facing PHCTs can be meet by developing creative and innovative solutions. The primary health care climate is ready for change and PHCTs need not be daunted by the challenges before them but rather inspired with various ways to create, build and sustain teams.
RECOMMENDATIONS

These interviews have provided a wealth of information from which we propose 7 recommendations. We feel the following recommendations, if enacted, would support and sustain future PHCTs.

1. Develop and disseminate a tool/instrument that would help teams determine/measure whether or not their team is working well;

2. Establish conflict management strategies and protocols;

3. Engage in team-building activities to develop and sustain a collective identity as a team and strengthen a shared philosophy;

4. Encourage and support on-going opportunities for informal and formal communication (i.e. team meetings);

5. Establish leadership that has a clear and defined presence and is recognized by team members as providing direction;

6. Develop a clear understanding and respect for the ways in which each member can contribute to prevention and health promotion and;

7. Provide adequate funding and resources, including appropriate time and space, for health care providers to work in a team environment.
1. INTRODUCTION

No one healthcare professional can address the complex and multifaceted needs patients currently present in the primary health care arena. This reality is recognized by both health care providers and funders in the primary health care sector who support the development and implementation of interprofessional, collaborative teams. Yet fundamental questions remain: how will interdisciplinary teams be organized; what will be their composition and function; how will they be sustained; and what are the indicators of well functioning primary healthcare teams (PHCTs).

This document describes the findings of a large qualitative study conducted with three types of primary health care teams in Ontario. The purpose of this qualitative study was to identify and examine issues and challenges to teambuilding and teamwork amongst teams in primary healthcare and to explore their prevention and health promotion strategies.

2. METHODOLOGY

2.1 Methods

This was a phenomenological qualitative study using in-depth interviews to collect data from a wide range of healthcare professionals working in primary healthcare teams.

2.2 Study Context

The study data was collected in the province of Ontario between August 2004 and October 2005.
2.3 Sample Selection and Recruitment

The goal of the sample selection and recruitment was to secure a maximum variation sample with regard to location (urban versus rural), and practice type including: Family Health Groups (FHG’s) and Family Health Networks (FHNs); Community Health Centres (CHC’s); and Family Practice Teaching Units (FPTU’s). The teams also had to vary in their composition and size.

Several sampling techniques were used to recruit the participants. Potential teams were identified through a number of sources including: a list of FHG/FHNs provided by the Ministry of Health and Long Term Care (MOHLTC); a list of all of the CHC’s in the province supplied by Association of Ontario Health Centres (AOHC) and; the FPTU’s identified through academic Departments of Family Medicine in Ontario. Potential participants were first mailed a letter of information detailing the study. The letter also indicated that participants would receive a $75 gift certificate for their participation. Seven to ten days following the mailing of the letter the practice sites were contacted by telephone to determine their interest in participating.

2.4 Data Collection

A semi-structured indepth interview was conducted with each participant by one of two investigators (See Appendix 1 for Interview Guide). The interviews were conducted at the practice site and lasted 1 hour on average. A brief description of each practice was developed to capture the context and field notes were generated for interviews as needed.
2.5 Data Analysis

All interviews were audiotaped, transcribed verbatim and subsequently checked by the original interviewer for accuracy. In the first phase of the analysis each transcript was independently reviewed and coded by a minimum of two researchers to determine the key concepts and/or themes emerging from the data. The next step in the analysis involved a meeting of the researchers to compare and contrast their independent coding, culminating in a consensus that informed the development of the coding template. The coded transcript was then forwarded to the research assistant to input into NVIVO (QSR NVIVO2). The second iteration of the analysis involved generation of reports for each of the main themes with exemplar quotes illustrating the themes. The research team then met for further synthesis and interpretation of the themes. The techniques of immersion and crystallization were used throughout the analysis process. Theme saturation was achieved by approximately the seventy-fifth interview. However, the researchers were committed to ensure all the different practice types and team members had an equal voice in the research process and thus completed the data collection and analysis on all 121 interviews. Credibility and trustworthiness of the data was enhanced through three principal means: interviews were transcribed verbatim, field notes were taken at the interview site to facilitate accuracy of data interpretation, and a minimum of two researchers read and analyzed the data independently and then came together for team analysis.

2.6 Ethics Approval

Ethics approval for this study was received from The University of Western Ontario’s Review Board for Health Sciences Research Involving Human Subjects (Review #10949E)
2.7 Final Sample and Demographics

The final sample consisted of 16 primary healthcare teams with 7 FGH/FHNs, 5 CHC’s and 4 FPTU’s. In total 123 interviews were conducted. However, it became apparent during one interview that the participant was not in a team setting and therefore did not meet the inclusion criteria and another interview was eliminated due to a technical failure. Therefore the final sample consisted of 121 participants (Table 1) whose job titles are reported in Table 2. The average age of the participants was 46 with a range of 25 to 65 (Table 3) and they had been a member of their team for an average of 8.8 years with a range of 2 months to 35 years (Table 4). The size of the teams ranged from 5 to 35 team members. There were 10 urban sites and 6 rural sites.

<table>
<thead>
<tr>
<th>Type of Team</th>
<th>Teams</th>
<th>Individuals Interviewed</th>
<th>% of Total</th>
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<tbody>
<tr>
<td>FGHs, FHNs</td>
<td>7</td>
<td>38</td>
<td>31.4</td>
</tr>
<tr>
<td>FPTU</td>
<td>4</td>
<td>33</td>
<td>27.3</td>
</tr>
<tr>
<td>CHCs</td>
<td>5</td>
<td>50</td>
<td>41.3</td>
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<tr>
<td>Totals</td>
<td>16</td>
<td>121</td>
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Table 2. Healthcare Professionals included in the interviews

<table>
<thead>
<tr>
<th>Job Title</th>
<th>FHGs/FHNs</th>
<th>FPTU</th>
<th>CHCs</th>
<th>Total</th>
<th>% of Total</th>
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</thead>
<tbody>
<tr>
<td>Nurse – RN, Public Health Nurse, Head Nurse</td>
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<td>4</td>
<td>2</td>
<td>15</td>
<td>12.4</td>
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<tr>
<td>Nurse Practitioner</td>
<td>-</td>
<td>3</td>
<td>10</td>
<td>13</td>
<td>10.7</td>
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<tr>
<td>Nurse – RPN, Nurse Educator, Diabetes Nurse Educator, Lactation Consultant</td>
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<td>2</td>
<td>4</td>
<td>9</td>
<td>7.4</td>
</tr>
<tr>
<td>Physician – Family Physician, Family Practice Residents, Locum</td>
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<td>6</td>
<td>9</td>
<td>30</td>
<td>24.8</td>
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<tr>
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<td>1</td>
<td>5</td>
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<td>8</td>
<td>6.6</td>
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<td>Business Director, Program Director, Team Director</td>
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<td>3</td>
<td>2</td>
<td>6</td>
<td>5.0</td>
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<td>Reception, Medical Secretary, Clerk, Admin Assistant</td>
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<td>5</td>
<td>4</td>
<td>13</td>
<td>10.7</td>
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<td><strong>50</strong></td>
<td><strong>121</strong></td>
<td><strong>100%</strong></td>
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Table 3. Age of Participants – All interviews

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<th>Age at Interview</th>
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<th>FPTU 33 Respondents</th>
<th>CHCs 50 Respondents</th>
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<td>25 to 65</td>
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<td>46.8</td>
<td>43.5</td>
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Table 4. Years at Site – All interviews

<table>
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<th>Years at Site</th>
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<th>FPTU 33 Respondents</th>
<th>CHCs 50 Respondents</th>
<th>Total Sample 121</th>
</tr>
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<tbody>
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<td>Range:</td>
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<td>0.3 to 31</td>
<td>0.17 (2 m) to 17</td>
<td>0.17 (2 m) to 35</td>
</tr>
<tr>
<td>Mean years:</td>
<td>13.0</td>
<td>7.2</td>
<td>6.5</td>
<td>8.7</td>
</tr>
</tbody>
</table>

3. FINDINGS

Three overarching themes emerged from the analyses: 1) What makes a team work – the foundation and pillars of teamwork; 2) internal and external challenges faced by primary healthcare teams and; 3) potential solutions and recommendations to help create, build and sustain primary healthcare teams. Analysis of the interviews also provided a “snapshot” of
the current prevention and health promotion strategies used by these teams and the community agencies and services most frequently accessed by the study teams.

3.1 What Makes a Team Work

The first overarching theme reflected in the data was “what makes a team work?” and participants identified four major components that come together to make a team work (Figure 1). The foundation of teamwork was a shared philosophy which was two-pronged: the first related to a shared vision of patient care and the second was the value placed on teamwork in primary healthcare. Three essential components or pillars of teamwork were cemented in the foundation of a shared philosophy: trust, respect and communication. As one participant stated: “The same philosophy, trust, respect, open communication.” Another participant explained: “You have to trust ... you have to know that they have integrity. I have to respect your knowledge and what you bring to the team ... Those are some of ... the pillars on which the team is built.”

Within each of these four components were specific attributes or actions which enhanced team functioning. When a team worked well there were observable indicators of success such as job satisfaction and patient-centred care. These in turn facilitated the experience of teamwork.
Figure 1. What Makes a Team Work: The Foundation and Pillars of Teamwork

Team Works Well

Job satisfaction, Dedication to work, Team as a family,
Adaptability to Change, Environmental Tone, Strategies to Manage Stress
and Conflict, Patient-centred care

Trust
- Relationship building
- Caring
- Scope of practice

Respect
- Reciprocity
- Feeling valued
- Work well together

Communication
- Openness
- Approachability

Shared Philosophy

Common Vision
Interprofessional collaborative team practice
(Continuity)

Personalities fit together
(Team history, experienced staff)

ABC - Foundations of Teamwork in PHC July 2006
3.1.1 The Foundation: A Shared Philosophy

A shared philosophy regarding the provision of patient care encompassed both a common perspective on the core values of primary healthcare and how patient care is delivered by the team. One participant described the concept of shared values in the following way: “[We have] shared values of caring about our clients and shared values of respecting clients and not judging some of the realities that we encounter here.” Another participant explained: “[We] generally have the philosophy that we want to make sure that our clients are well cared for. And I think that helps us keep our focus.” A mutual understanding and agreement about how patient care was to be provided by the team reflected their shared philosophy and is demonstrated in the following quote:

*I think we hold very similar values, which is really important. We tend to practice similar practice styles, similar standards about how we feel patients should be managed, how much time should be spent with a patient, these things are huge. ... we’re all working towards the same goal.*

Participants described how continuity of care was an integral part of a shared philosophy regarding patient care.

*That continuity ... and to have everybody working towards that goal. The whole continuity of care. I hate gaps in the day where a patient feels like they’ve told the same thing four different times to four different health professionals. I’d like a team where information is passed on easily from one person to another and that everybody is going for that same goal and I think that we have that pretty well developed at our [centre].*

Participants from FPTU’s described how a “shared focus” enhanced the teams commitment “to the care of patients...and the education of [family medicine] residents.” CHC participants, in particular, emphasized the core values of their organizations as caring not just for individual clients but communities as well.

*...we’re dealing with the person holistically. ...we’re looking at the patient, the family, the community. So we’re not just dealing on one sort of level with people.*
When I talk about community, we often do community events, we do a well woman evening and we bring in people that don’t have family docs...

Participants from all three types of teams expressed how a shared philosophy permeated their teams and involved all team members. “I think we all have a commitment towards providing good healthcare, whether it’s the physicians or the nurses or even the support staff.” In sum, participants' belief and commitment to a shared philosophy of patient care lead to a “team effort in the best interest of the patient”.

The second aspect of the foundation of a shared philosophy is the value placed on teamwork. This encompassed personalities and how well team members “fit together” and thus worked together. This was often related to the team’s history together and level of experience. Shared goals could also contribute to reciprocity among team members.

Participants frequently explained how “personalities that fit together” contributed to a shared belief in the importance, and ultimate success of teamwork. “I think that the personalities of the people involved are very important. I think common goals are important, and matching personalities.” Another participant at a CHC explained: “...personalities are a big part of that. I think we have the people who are committed to this sort of environment and this sort of approach, so that’s a big part of it.” The longevity of the team and the history they had created together also contributed to their shared philosophy regarding the value of teamwork. A participant captured this view:

... we’ve been together, most of us, a long time. We understand each other’s talents and foibles, and we’ve just learned to get along together. And actually, I guess the new members of the team have fit in very well and fairly seamlessly too. But a lot of it is just working together for years and years and knowing each other really well. We’re more like a family than a team I’d guess you’d say.
Connected to the concept of longevity as a contributor to a shared philosophy was how this perspective was translated from senior team members to new team members:

...the nurses that work with us have been in this kind of a group setting for some time. Most of the two more senior ones have actually been here for over 18 years and the newest members seem to fit in very well. So I think they also have that same appreciation for family medicine as a distinct way of looking at healthcare.

Also, senior team members had established the philosophy of care to guide the team and thus attracted future team members who shared a common perspective. “I guess the longest members here had the philosophy to begin with and I think that philosophy attracts similar people with the same ideas.”

The link between a shared philosophy and the concept of reciprocity is reflected in the following quote:

With the health promotion team I think it’s ... first of all we all get along very well together, so we, we think along the same lines. So we, we know what the goals are that we need to meet for the CHC’s mandates and we try and we try and help each other.

Finally, a shared philosophy regarding the value of teamwork in primary healthcare is captured in the following quote:

I think the people that work here have common goals and common ethics and we talk about the fairness aspect a lot ...you have to do what’s fair for everybody. And if it’s not fair for the group and it only benefits 1 or 2 people it doesn’t work. So I guess the group mentality rather than me, me.

3.1.2 Trust

Trust was identified by participants as one of the three pillars essential to a well functioning team. Trust reflected a sense of confidence in fellow team members. Key attributes of trust included an understanding of the team members’ scope of practice and relationship building. Descriptions of trust were intertwined with the other pillars and
concommitant attributes of good team functioning as demonstrated by the following quote. One participant stated how you needed to: “... trust your team members too and gain their respect that you can be trusted and I think those are important, communication and trustworthiness.”

Participants described how trust encompassed professionalism and awareness of each team members’ area of expertise.

*First and foremost I think it’s a trust. ... you want to trust in your team, you want professionalism, and you want everybody to be aware of what everybody’s special areas are of expertise and that way everybody can contribute the most they can.*

Trust was also enacted when team members worked within their scope of practice. Furthermore, it meant recognizing both professional and personal experience and the ability to communicate uncertainty about their skill set and need for additional training.

... understanding their skills, their own awareness of their abilities and their limitations and having a sense of trust or confidence that they’re going to work well within their scope of practice and not hesitate to seek assistance or guidance or whatever if something extends beyond that. ... So recognizing that people’s skill sets are not necessarily only tied to their professional qualifications but also their life experience and their years of experience. ...Communicating around those things and being open and honest around those things, and that kind of gets back to that first issue about trust. Sort of the trust [that] comes when people will speak up and say ‘hey, look, I’m not good in that area,’ or ‘I need to learn more or do more’.

The following quote reflects not only the need for trust but also a spirit of cooperation, a belief in best practices to avoid medical error, trust in a shared philosophy and finally – respect.

*Well the ability to trust each other’s judgment and the ability to know that other people will cooperate. I guess trust though is the most important thing. Trust that nobody is going to make a mistake and trust that we’re all in the same wavelength. ... Well, on a human basis mutual respect and trustworthiness, treating people the way they’d like to be treated.*
Participants strongly suggested how trust does not occur instantly but requires active relationship building among team members. Described as a ‘necessary feature of collaborative practice’, relationship building and developing trust requires time and effort.

Over the years as we have become familiar with each other’s work styles that there has been quite a trusting relationship established between the professionals...just the trust and getting to know each other that’s developed over the years.

Relationship building encompassed getting to know each other professionally and in many cases, personally.

We genuinely like each other. I really like coming to work because I really like the people that I work with. I’m very comfortable with them – I like to think they’re comfortable with me. We just get along so well that I trust them implicitly.

Relationship building was a result of going through stressful times with each other. One participant explained how at the end of a busy flu season the team was stronger:

It was the fall flu season [and] having gotten through that really strengthened our team as well. That’s another thing that probably made our team. I guess that kind of helped us as well as trust and respect.

3.1.3 Respect

Respect was a very prominent theme in participants’ descriptions of what makes a team work, and as such reflects the second pillar. “I think the core essence is the mutuality of respect. And respect both at the personal level as well as the professional level. So I think that would be the essence for me.” As with the other pillars, respect was clearly intertwined with trust and communication. “So there’s respect, there’s competence, there’s communication. I think those are the big ones.” Respect encompassed respect for team
member’s skills, ways of demonstrating appreciation, working well together, feeling valued and reciprocity.

Respect encompassed acknowledgement of other team members’ knowledge and skills. “Respect for each other’s knowledge and what each person has to contribute. That’s the only way a team can work I think.” Another participant expressed a similar view about respect on the team. “I would describe our team as strong, we work well together. I feel well respected in my own profession and as an individual and I respect my colleagues.”

Respect was described as essential in order to sustain a team: “Also respect for each other helps with sustainability as well because if individuals don’t respect each other on the team, the team’s not going to work and people just sort of go their own way.” Furthermore, respect helped build a team. “If you treat each other with respect then the sense of team comes.”

Respect for team members was enacted through recognition and acknowledging their contributions to the team.

Having respect for the people around you and demonstrating that in some way, shape or form, that’s crucial I think. And recognizing the hard work they’re doing and...having some way of acknowledging when people are doing a good job, that’s pretty crucial. When you [keep] peoples’ morale up it’s amazing how much more productive they are, it’s really amazing.

Participants highlighted the importance of experiencing respect from all members of the team.

... there’s a thread of respect I think right from our manager right down. She really highly respects us as individuals, our background and our training. And I think we have a respect for each other. Everybody has their own unique expertise and we really respect that.
Furthermore, participants spoke in detail regarding the link between respect and feeling valued.

*Being respectful and in terms of keeping the relationships well oiled and comfortable, generally speaking. … the people who are the most powerful people on the team have always been, in my experience, pretty respectful of the contribution that everybody on the team can make. … just a little bit of time dedicated to teamness, and the work and talking about what the team needs to do. So a little dedicated time for appreciation and that’s part of respect I suppose.*

Reciprocity among team members was described in the context of mutual respect and was reflected by team members stepping in to help when needed and knowing others would do the same. This was also linked to participants’ descriptions of working well with team members.

*I think that the main thing is respect for each other. The idea that everybody does a really good job at their particular job and everybody tries to help each other. I think that’s really important here. If you don’t help each other you’re sunk. And we have a really good team that way.*

### 3.1.4 Communication

Participants described many mechanisms through which information was communicated within their teams. However, when talking about what makes a team work, the participants described a different aspect of communication – the act of exchanging, sharing and receiving information, an act so important to team functioning. Therefore, the third pillar of teamwork was communication and was described by many participants as one of the essential components of teamwork. *“What makes our team work? Communication number 1.”* They also perceived good communication as *“build[ing] a better team.”* Again, the interconnection with the other pillars of teamwork were apparent as the following quote reveals:
I think the key is excellent communication. And I think the other key is respect for each other and that we’re all treated equally and recognizing that everybody plays an important part in making this team work for our patients. I think [those] are the primary two – communication and the respect.

Participants described several positive aspects of communication which facilitated team functioning. They explained how their teams “communicate very easily” and have “very open communication.” In addition, they spoke about “clear communication, both giving and receiving”. Therefore reciprocity was also a characteristic of good communication: “I think it’s the give and take and the back and forth communication”.

Along with open communication was a sense of approachability. A safe and approachable environment allowed team members to communicate openly:

*I think that one is an openness to the group to say their piece without getting shot down. We try to have a fairly open door policy that there is no door basically. ... So anybody can say what they think. Folks are encouraged to take initiative.*

Feeling comfortable in bringing forward concerns or issues reflected open communication.

“I think it’s just a very open environment where people feel comfortable and feel they can, if they have issues, they can come and talk to whomever.”

Good communication was an active process. As one participant described: “I feel, if you really like your job and what you’re doing then you’ll work hard at making sure the lines of communication are open because you want it to work.” Participants also explained how communication was central to the day-to-day functioning of their teams.

*I would say if everything seems to be flowing smoothly and there’s been communication, [for example], ‘I’m not going to be here tomorrow but this is what was happening with this, or this is what needs to be done with this yet, could you look after it for me?’ Communication really plays a major role.*
Participants described the key role of communication in assisting teams to view themselves as a “team” versus a collection of individuals while at the same time respecting and validating each individual on the team.

*We need also honesty between people, and communication skills, very high communication skills to make it work. ... I try to look at the larger picture. And in doing that it is also to take care of individuals, cheering up, inquiring ‘Is everything okay with you? What’s wrong? What do you see that is not working out there, or, what gets on your nerves?’ Have people talking, it’s communication really. So that is to reach them as individuals because a team is made of individuals. Probe them, ask them, support and offer help...*

Participants identified the need for regular opportunities to communicate, such as team meetings: “Communication is so important and I mean like regular communication. I think the team should be meeting a lot more frequently than once a month. I think it should be once every two weeks.” Regular team meetings permitted a sharing of knowledge about patients and a time for ‘team-ness’.

...what makes our team work. I do think the regular team meetings are important and when there have been teams that don’t adhere to that, I very much noticed a watering down of our knowledge of what each other can give and a watering down of our shared knowledge of patients. Where the shared knowledge would have been a good thing and would have been a helpful thing for the care of ... patients. So the adherence to some regularity of meeting I think makes a difference. ... just a little bit of dedicated time to team-ness, and the work and talking about what the team needs to do.

The previous quote and the one following highlight the importance placed on making and taking time to communicate. “... time for communication, you absolutely in a collaborative practice need to build those time[s] to talk to each other, to have communication.”

Participants also noted the importance of timely communication and the transfer of relevant information in order to problem solve and provide patient care. “...we have a strong communicative base here. If there is an issue at all, people sit down and talk about it. We’re really good at problem-solving things related to patient care.” Timely
communication also assisted teams in addressing issues before they became a significant problem. This ability to communicate and problem solve was enhanced by respect and accessibility to team members.

I think the reason is because there’s a lot of respect between team members. There is a lot of communication. So we don’t shelve things until they become bigger problems, we try to deal with them when they’re smaller. There’s, along with the respect goes the availability of team members to each other, so everybody is accessible somehow, either through email or face-to-face.

Thus, as participants indicated, a team that works well is characterized by an underlying shared philosophy espoused by all team members. Upon this foundation of a shared philosophy rests three pillars of teamwork: trust, respect and communication. With these components a team is able to function. The following section describes observable indicators of when teams are working well.

3.2 Indicators of When a Team Works Well

Once a solid foundation of a shared philosophy was in place, and the pillars of trust, respect and communication were established, indicators of a well functioning team became evident. Participants from all three types of teams described a wealth of activities, experiences and strategies as indicators of a well functioning team including: job satisfaction; dedication to work; experiencing the team as a family; adaptability to change; environmental tone; patient-centred care; strategies to manage stress and conflict and; patient-centred care.
3.2.1 Job Satisfaction

Participants explained how job satisfaction clearly reflected when their team was working well together. “Our particular team works because all of us basically enjoy what we do.” Another participant stated:

We have 7 happy doctors, we have happy support staff, we cover our emerg. in the hospital, we cover our hospital, it doesn’t get any better than this and we all have happy lifestyles. We’ve all raised our kids and the new ones are raising their kids, and they’re happy to come to work. I defy anybody to find that anywhere else in Ontario.

Job satisfaction also reflected the presence of reciprocity on the team and the ability to approach other team members for help. One participant described how this was an indicator that their team was functioning well. “I just feel satisfied at work and not feeling stressed out. I mean if you’re feeling that you know you can go to anyone to ask for whatever and not worry about it then you know your team’s working.” As another participant succinctly stated: “If we didn’t enjoy doing it [work], it would sort of fizzle and fade.”

3.2.2 Dedication to Work

Participants expressed dedication to their work as an indicator of the team working well and this was linked to their stated satisfaction. “All of us enjoy our work here. We’re very, very dedicated.” Another participant explained:

There is a strong devotion to our patient roster here. The clerical staff in particular have been here for a number of years as well as the physicians and they’re just so devoted and that translates into trying to make things work well in order to please our patients and have a successful operation.
Dedication went beyond patient care and was reflected in the team members’ dedication to each other and the processes which make a team work. As one participant observed:

_The team works because people are dedicated. People that are dedicated are going to show up at the meetings. They’re interested, they’re going to take part in the decision-making process. They make time to be there. They answer e-mails. They follow up. The team works when they’re involved._

### 3.2.3 Experience the Team as Family

Many participants described how they experienced their team as being like their family and viewed this as a strong indicator of when their team was working well together. Participants described this sense of team as family in the following ways: “We support each other.”; “We look after each other.”; “Being there for each other.”; “Looking out for each other as individual people.”; “Sensitivity to another person’s feelings.”; “We sort of refer to the whole clinic as an extended family. It’s a very close group of people.”

There were several dimensions to the concept of the team as family and in many ways these reflected the culmination of several team characteristics described throughout this document including: team longevity, respect, reciprocity, care and concern for fellow team members and, sharing life events. Teams who had a long history of working together often described their teams as a family. As one participant explained: “We have worked here that long, I just feel like I have my family at home and I have my family here.” Another participant stated: “It’s almost like being married especially when you’ve been working here that long. You get to know the people really well.”

A feeling of being respected and the reciprocal nature of the teams fostered a sense of family. One participant captured this perspective:
I think everybody really respects people’s feelings and you just try and help each other out as much as you can and that’s the bottom line. Just try and do your job and help other people with theirs if they need it.

A sense of family was also reflected in the care and concern expressed for fellow team members. The following participant described how a sense of family was enacted by the actions of the doctors on their team.

We’ve been very fortunate with the doctors we have working here. They display concern for us both as employees and as people if we have a personal issue that we need to take care of they’ve always given us the time and the space to do so. They have a concern for us on a personal level as well...I think we’re a bit of a family in the office. So, it’s nice.

Finally, comfort in sharing life events fostered the experience of teams. As one participant expressed: “We’re very good about sharing life events...We keep our colleagues involved in the important things in our lives.” The following participant expressed her appreciation of the experience of the team as family when her father died:

I think again we keep the communication lines open. We’ve had a lot of situations where it’s been really bad- like a death in the family. I know when my Dad died this happened. Communication, I think it’s the only thing to do. If you bottle it up inside it’s going to blow sometime. You’ve got to talk and we’re really close that way, everybody’s very in tune to our moods, and again because for the most part we’ve worked together for a very long time.

3.2.4 Adaptability to Change

Another aspect characterizing a well functioning team was their adaptability to new ideas, new team members and change within the organization. When responded to with openness, receptivity and acceptance, teamwork was enhanced. Many participants described how their teams were responsive to new ideas.
I find that everybody is very responsive to everything, whether it be from the directorship on down. If I have a new idea or a new program I wouldn’t hesitate to [bring it forward]. It’s a real nice 2-way street that we have.

“Innovative” teams responded with enthusiasm to the healthy challenge change provided.

Well you can tell when you’re discussing it that they’re really upbeat, and ‘Oh, let’s try it!’. They get really excited about something that’s new and it’s kind of a challenge, ‘Let’s do it, let’s see how it works.’ Because they want to improve the quality care. They’re very, very caring. Quality care, speed, and how you can look after the patient better.

Participants who were relatively new to their teams described feeling a sense of openness to change:

I know when I’m starting a new job that I’m jumping into the lake ... I am creating waves that affect other people and in some ways, I’m asking that other people get wet. Because I’m creating change and I have found here that people have been very open to those changes ...

Change could be experienced as unsettling, yet the end goal described by participants was improved team cohesion and ultimately better teamwork.

I think it’s just trying to adapt as much as you can and trying to keep an open mind that things may seem really hairy and out of control today, tomorrow, maybe next month, but there is a light at the end of the tunnel. This is all working towards a better and more cohesive functioning.

This could be enhanced by a comprehensive orientation to the team and overall functioning of the organization.

There’s a whole big initiation program here. Takes about a week and the person, the administrator takes them around to every single person, introduces them, and explains the role of every employee in the place, shows them how to run the computer, shows them how to put files away for filing, who to talk to ... it’s a complete initiation process that goes on.
Finally, participants highlighted the importance of keeping “people interested. You keep changing things. Opportunities to grow.” This was related to opportunities to bring forth new ideas. “My feeling is that everybody’s quite responsive to new ideas. They’re definitely willing to talk about them. Most people are willing to try them, so usually there’s a positive response to new ideas.”

3.2.5 Environmental Tone

When a team was working well participants overwhelmingly described a team environment in which: “People are happy. They like coming to work.” Another participant explained: “I can only describe it as a feeling like everything is clicking, connecting. People are in good spirits, the care we’re providing, we’re happy with it. We’re getting sort of a positive reinforcement that we’re doing a good job.” This was in contrast to when team members were “grumpy” or “snapping at people”. In essence, when a team was working well there was an atmosphere in the office, or an environmental tone, reflecting a sense of “chemistry in the office” and one which created “a good atmosphere”.

A prominent aspect of this environmental tone was humour.

*We laugh, we have fun. Everybody has a very good sense of humour for the most part. We’re in a business that there are very serious situations that people are going through and I think that you have to be able to find a sense of humour in a lot of situations or you will be in trouble working in this business.*

Participants explained how, when the team was working well together, they were “smiling...telling each other about their lives and sharing jokes...humour in the room...it’s part of the barometer.” In contrast, when the team was not functioning well participants noted “everybody’s grumbling and muttering and not their usual happy selves.” Again, a
combination of openness, humour, and reciprocity were indicators of when a team worked well together. A participant explained:

> We’re very relaxed here so we’re very open with each other and we all have a very good sense of humour which seems to help on a day to day basis. Everyone seems to be willing to pitch in where there’s spots that need to be pitched in. We seem to really work well together, all of us.

Over and over again participants used the word “happy” to describe when their team was working well. The following quote expresses this infectious quality:

> If I see people being happy, I know that sounds kinds of corny but that’s how I know. I can tell just by how people are looking, how people are behaving and if people are chatty and that sort of thing you know things are good. If they’re not, then I know something’s up.

### 3.2.6 Strategies to Manage Stress and Conflict

Participants described how having strategies in place to manage stress and conflict were also indicators of a well functioning team. These strategies could be informal, such as talking with each other to alleviate the stress and once again highlights the pillar of communication. “Communication, I think it’s the only thing to do. If you bottle it up inside it’s going to blow sometimes. You’ve got to talk, and we’re really close that way.” Another participant stated: “Just trying to talk about. Trying to get people to say, ‘What is it? Is something bothering you?’ We are pretty good at that.” In addition, the use of humour was a means to defuse stress on the team. One participant explained:

> …we joke around a lot. I’ll be in the doctor’s office getting charts or whatever, and I’ll make a real funny comment and they’ll start laughing, even though they’ve been stress or something. And I think, you have to be like that otherwise you’d just always be stressed.

Participants also described more formal and organized strategies to address team stress.
The staff itself get together like I said every 3 months. So they may blow off some stress and steam that way. But I would suggest that we make fun of each other a lot. And that deals with stress.

Finally, another participant observed that when organizational structures were in place the team worked well. However, when the stress experienced on the team impeded their ability to sustain themselves there could be a tip in the “balance” with a detrimental outcome.

I think when you’ve got a good organization and everything is in place it’s invigorating and...people are energized, proud of what they are doing, but there’s a tipping point beyond which it doesn’t sustain itself. It becomes problematic...there’s another level of stress ‘cause it’s no longer fun and people feel...like they’re doing more than the next guy...People don’t feel like it’s a team that’s really pulling together.

Similarly, participants described both informal and formal strategies for conflict management on their teams. Once again, the pivotal role of communication was apparent. “It has to be communication, it’s the only way.” On an informal level conflict was addressed by open and direct communication. “You have to be open, honest and sincere with the person you are in conflict with.”

Open communication also required assuming responsibility for contributing to the conflict. As one participant stated: “I am not shy about going and apologizing and saying ‘Yes, I am sorry, look I made a mistake here.’” Another participant stated:

I think what can alleviate conflicts is just being open and saying, you know, ‘this is what’s happened. I don’t feel comfortable with this.’ Being able to sit down and discuss it and work through. Maybe throwing out some different ideas as to how something could be resolved and then coming to an agreement on which one would be the best for both parties involved.
In addition, humility facilitated conflict resolution and was linked to listening to all the parties involved. “Humility is a big thing. Just being willing to say that I don’t know everything. And along with that goes a willingness to listen to both sides of the story.” Open communication also enhanced problem-solving skills as the following quote reveals.

“…people are pretty open in talking about a conflictive issue. They have good problem-solving skills. People will come to a table and say ‘okay, this is the issue, let’s work it out, let’s resolve it.’”

Another pillar, that of respect was also pivotal in conflict management. “Respect for all the parties involved and trying to ensure open communication.” Another participant stated: “I think developing respect again for each other’s roles is a facilitator to conflict management.”

Formal strategies to manage conflict within a team included conflict management protocols and a reliance on “leaders” to negotiate and resolve the conflict. Participants described how their teams had developed and implemented specific conflict management policies and procedures. This was most evident in the CHC’s.

There is a process in place that if we do have a particular conflict that we have a policy in place so that we, there’s sort of a hierarchy of where you need to go for what particular reason. So there are policies in place to support individuals.

Overwhelmingly participants explained how conflict management strategies were primarily enacted by “leaders” on the team. In FHGs/FHNs and FPTUs this role was often assumed by the family physician(s). “I think all the doctors here are very good facilitators. Very good listeners and would probably be easy to approach and would give suggestions or may
approach that person to try and resolve something." Of note, none of the CHC participants identified the family physician(s) on their teams as serving in this role.

In both FHGs/FHNs and FPTUs the task of conflict management was sometimes transferred to designated staff, such as an office manager, who was empowered to address and resolve the conflict.

...I think the fact that we have an officer manager. She is kind of a facilitator because she is like a ‘go between’ between the doctors and the staff going either way. So if there’s something that one particular person isn’t comfortable approaching another person then the office manager can be like a go-between.

Another participant described the business manager’s important role in conflict management.

...our business manager is very good. He has wonderful people skills. He doesn’t miss a beat and he can sense when there is a problem and he’ll wait for you to come to him but he’ll find a way to get to the bottom without even letting you know he knows about what’s happening so he’s really instrumental in keeping things on an even keel here.

On CHC teams, the individuals most likely to be assigned a leadership role in conflict management were the Executive Director or their designate, such as a Team Manager. As one CHC participant explained:

If we need to bring in our manager then we do and she’s very open. She’s also trained in mediation which is very helpful. She seems to be able to facilitate any disagreements and get us to be able to air what we need to air.

Another participant’s comments once again reflect the centrality of communication: “I think you need somebody who’s really good at really being able to listen and to hear people and then to come out of that with really good, constructive suggestions after having listened to everybody.”
Regardless of who assumed the role in leading the conflict negotiation and resolution process, participants anticipated the following attributes and actions as being present in a good leader:

_They’ve to have an open door policy, they’ve got to be accessible, they’ve got to be non-judgemental, they’ve got to be able to listen and they need the certain mock and mood wisdom. As long as there is the opportunity to ask for support and recognize personal limitation, and there’s got be a certain humbleness about how leaders actually are involved. If you don’t have solutions see if you can find them._

### 3.2.7 Patient-Centred Care

Participants described how when the team worked well together this was reflected in exemplary patient care. “We think patients are our best indicators of how the team is working because when we do work then they’re taken care of and they’re happy with the care that they receive.” As another participant stated: “The bottom line is patients care.” Also, when the team was working well there was patient satisfaction and good clinical outcomes: “Our team is working very well because the patient satisfaction is very high and our clinical outcomes are pretty good...[and nothing has] really slipped through the cracks.” Another indicator was when “patient issues are being heard and addressed, [then] we are working as a team.” This final quote demonstrates the link between good patient care and the atmosphere on the team. “I’d say that’s what shows that it’s working because, you know patient care gets taken care of and there’s an atmosphere of congeniality and cooperation.”

Therefore, according to the interviews, there exist several indicators of when a team works well. As discussed above, these indicators include job satisfaction, dedication to work, experiencing the team as family, ability to change, environmental tone, stress and conflict management strategies and patient-centred care.
Along with the above themes (What makes a team work and Indicators of when a team works well), participants highlighted some of the challenges to teamwork. The following section will explore these challenges in detail.

### 3.3 Challenges to Teamwork

The challenges to teamwork, described by the participants are divided into internal and external challenges. While they will be discussed separately, they are inextricably woven together. Internal challenges faced by these primary healthcare teams related to: team composition, roles and scope of practice; leadership; accountability; and barriers to conflict resolution. Participants described four major external challenges to team practices. These included: human health resources; patient expectations; resources and commodities such as time, funding needs, and workplace environments; and patient access and wait times.

#### 3.3.1 Internal Challenges

**3.3.1.1 Team Composition, Roles and Scope of Practice**

A major internal challenge identified by participants were issues surrounding team composition and roles, including how role boundaries were established and how role blurring was addressed. The internal challenges of establishing and enacting each member’s role, function and tasks on the team were intertwined with leadership, scope of practice, and accountability issues. A lack of understanding of team member roles and how they contribute to create a whole was described as leading to conflict, incomplete tasks, and impacting on patient care.

*I think sometimes … that people don’t understand each other’s role and how important each other’s roles are in that interdisciplinary team. You know it comes*
down to each of them, someone understanding the importance of each one of those
disciplines in that patient care and putting the patient first. ... So I guess it’s to have
clarity of the roles of each person and the importance of the roles and then make it
about what’s best for the patient ...

When team members did not have a sense of the team as a whole, especially the shared
philosophy of care, individual members worked in isolation and not in coordination with
other professions. As one participant observed: “The big things don’t get done because
everybody’s got their own little piece of the pie and this office has not done a really good job
of putting it all together.”

Role boundary issues were complicated and encompassed “... who is in charge of
what and who shouldn’t be doing what”. This related to defined roles versus blurring of roles
– some participants preferred a defined role: “... in fact we lost a good staff member at one
point because she wanted a more defined role.”; while others endorsed the concept of being
more flexible about delineating roles.

I think that’s a significant problem ... it’s a lot better than it was. There’s a change.
There used to be a real ‘I’m the doctor, I’m the nurse, I’m the pharmacist, I’m the
social worker.’ I find personally that those lines are blurring in the sense that people
don’t get uptight about delineating their role so much now.

Practice setting and lines of accountability were also identified as having an impact on how
roles were defined within teams. For example some participants, who described FHGs/FHNs
as a more traditional environment, suggested some team members, such as doctors and
nurses could have difficulty with role definitions and accountability. As one participant
explained:

More between the nurses and physicians ... some nurses don’t want to do certain
things like ... ear syringes and they say ‘maybe the physician should do that’, and ‘we
feel that’s not our position to do’, and ‘that’s a delegated duty’.
Problems related to scope of practice and lines of accountability were exemplified when new professions were added to teams. This was particularly challenging when the professional roles and responsibilities of new members potentially ‘threatened’ established scopes of practice. For example, with the addition of nurse practitioners to one team, a physician responded: “There’s some reservation and some hesitation”. Some physicians framed their reservations as concerns about the expertise, commitment and efficiencies when new professions are added:

… physicians are within the team, the family health care team that is coming up. Physicians are going to be expected to be working with a lot of other health care professionals. Already there’s talk about having psychologists, dieticians, nurse practitioner[s] involved. Physicians who are in practice who are self-employed have to work pretty hard. They see lots of patients, they push them through, they have to. I mean you have to work fast and efficiently. People in salary positions who are in a unionized position do not have to see the same numbers that physicians have to do. So there’s going to be a perceived difference in approach and is it importance [and] a feeling of commitment … It is a problem with other people doing the things that I do now, the well baby care and the hypertensive control and the things that I hear are supposed to be taken over by nurse practitioners. It’s going to be a concern whether they can actually do those sorts of things in an efficient manner as the physician can do. And will they have the training to do it as well.

As one physician observed, there are issues of trust and lack of familiarity about how other professions are trained.

The physicians are going to have to be working in an environment where other people are going to be doing some of the things that they have always been doing. Can you trust that it’s going to be done well? I don’t know how other people have been trained. I know how physicians are trained. I work with physicians all the time. I have very little experience in the training of other professionals and knowing what’s involved in the training.

Concerns about territoriality and patient continuity were expressed by other physicians: “...there’s territoriality that we are not talking about very much.” Another physician spoke
about the importance of the patient-doctor relationship and the role of continuity in patient care.

... there’s some real concerns that I have about what happens with continuity for the patient when you have multiple primary care givers. The model of primary care I did for 20 years and to a large extent I’ve maintained is very much a personality-dependent relationship. ... I have an incredible loyalty to my practice. ... And those patients have stuck with me ... Well what happens when I stop having that connection?

Finally, one physician anticipated being left with a practice heavy in complex and challenging care if nurse practitioners assumed responsibility for the healthy patients:

If I get the nurse practitioner to see all the simple stuff, it increases my burden, because I’m stuck with difficult stuff, probably with the same amount of time and with no relief in between. And it’s actually the simple stuff that gives you pleasure, because you see the whole life cycle, not just the unhealthy. ... you need balance and you need to see the whole family to really be a family doctor. So that means both the sick ones and the healthy ones.

Those in the more established roles were not the only participants to express frustration and concern. New professionals such as nurse practitioners and health promotion specialists described a lack of sharing and collaboration making their integration into existing teams a challenge.

At this stage of the game I’m still not getting a lot of sharing [with] the physician bringing clients to me. Another piece of collaborative practice is respect for each others’ knowledge base [and] skill base. I think the respect is basically there. It’s probably the joint problem-solving that I don’t think we’re quite made it to yet. I mean physicians aren’t educated for collaborative practice. They are educated for solo practice and...that’s the way they think and unless structures are set up to inform them differently, then we are not going to have collaborative practice.

Part of the role tension was attributed to a lack of understanding of the roles and responsibilities of other professions. Furthermore participants commented on how there was
a lack of awareness of the unique and valuable contribution other professions could make to the team.

I think sometimes that people don’t understand each other’s role and how important each other’s roles are in the interdisciplinary team. It comes down to each of them understanding the importance of each one of those disciplines in patient care and putting the patients first.

In addition, lack of a shared philosophy could exacerbate role tension. As one participant noted: “What I’ve discovered is that some of the challenges might be philosophical differences in terms of the type of care that you deliver. The model of care—medical model versus multidisciplinary model.” Philosophical differences between teams was most striking in the participants’ descriptions of the dynamics between the clinical teams and community teams at CHCs as illustrated in the following quotes. The first quote reflects how members on the community team often feel a need to justify their existence while valuing the contribution of the clinical team.

... we often feel that we spend a lot of time trying to prove ourselves. ... I’m not sure that the primary care team actually feels that they need a community services team in order to do their job. We though in turn, do need their expertise, their willingness to participate. As so there’s just a bit of a challenge, and certainly time constraints, our primary care team is extremely busy.

This second quote exemplifies both a lack of shared philosophy of practice and the inherent frustration when collaboration between teams fails to transpire.

I realize [the] primary team has a different role to play and they have times for appointments ... whereas the community team is much more flexible. ... primary and community tend to have a bit of a rift because, we do try to work together and we do bring practitioners in to our community programs as guest speakers or as consultants and we hope they’re promoting our programs as well, but somehow that doesn’t always work in reality.
Finally participants acknowledged the time and effort required to learn how to be a collaborative team. “It always takes time to learn to work together.” One participant described how it was not an issue of role boundaries or role blurring but rather time to enact the process of collaborative practice.

... the boundary issues are not particularly complicated. The nurses say they’d like to do more ... the physicians would like them to expand their scope, but the environment and everything else prevents it from happening, and stalls the process. And I think that is really quite different than being involved in a team where the whole variety of disciplines all collaboratively looking after the same patients. We wouldn’t have a hope of pulling that off right now, because of the lack of meeting time and things like that.

3.3.1.2 Leadership

Participants strongly endorsed the importance of leadership in supporting and guiding the organization and function of primary healthcare teams. Two main themes emerged from the analysis of the data regarding leadership: (1) the role of leadership in relation to business processes and practices; and (2) the influence of leadership styles on the team as a whole as well as on individual team members. While these two themes will be presented separately, they are inextricably woven together in the lived experience of the participants. It should be noted that these leadership styles were not specific to practice type (FHGs/FHNs, FPTUs or CHCs), but were evident across all team types.

3.3.1.3 The Role of Leadership on Business Practices and Processes

Participants described the key role of leadership in creating an organizational environment, which both fostered business practices and supported business processes. From a broad perspective leadership was seen as providing “checks and balances” [and opportunities] to pick up things before the get way out of hand”. Participants identified
specific activities as enhancing business practices including regularly scheduled meeting with staff and management.

Formally when we have our meetings. We have a physician office manager, we have a physician secretary and the office manager comes to them and we go through the old business, we go through the new business. We each go around the table and bring up points for discussion that we want to bring up or beefs that we have. We do that once a month.

In addition, written job descriptions for all team members assisted in classification and added clarification of team roles and functions. “What makes it [the team] work is the clarity of roles and processes”. Clear job descriptions also promoted the expression of explicit expectations of team members. “It is very important to set out the expectations of the job, set out what they do in the job and...your expectation of their attitude towards the job”.

Linked to clarity of role expectation was the value of annual performance reviews conducted by leadership. Performance reviews served as a venue to formally recognize and express appreciation regarding the team members’ contributions to the organization.

We do an evaluation of the team, by the team, and by the physician owners/managers. The physicians all do an evaluation of each of our employees. Employees do an evaluation of themselves. We compare notes...The reason we brought this in was that if you do a good job, too often nobody ever says that you do a good job. So if you’re not doing a good job for labor law you need to document that over a period of time and the employee was given the opportunity to improve. And if they’re doing well and most of our people are doing well, they’ve been with us a long time and they know what we want, they need to get a pat on the back that says, ‘Wow, you’re doing a great job again this year!’ But they don’t hear that if you don’t take the time to evaluate them. So that’s important.

Furthermore performance evaluations provided a forum for team members to communicate their interests and concerns in relation to the work environment and their own personal performance. “I think performance appraisals are a good time to discuss certain things you might not be happy with and you meet with the boss for that reason”.

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Leadership supported business processes by developing and following a well-delineated business strategy. This could be a challenge for healthcare professionals with limited exposure to business management training.

Even though I work in the medical field, we now live in an age where we have to follow business strategies and some of us working in the medical field, that’s probably our least effective means of working. Meaning that when we were trained, it was being the caring, empathetic health team member. But we also have to carry a fiscal responsibility which required us probably to understand the importance of demographic information.

Finally, participants described the importance of having inclusive hiring strategies.

Participants repeatedly indicated the value in participatory hiring practices that included relevant team members. This ensured a goodness of fit not only with the roles and expectations of the position, but with the team members as a whole. “The most important thing is to hire good people...It is very important to set out the expectations of the job, set out what they do in the job and...your expectation of their attitude towards the job”.

The Influence of Leadership Styles on Team Members and Team Functioning

The importance of leadership and the crucial roles leaders play on primary healthcare teams was prominent in the participant interviews. In particular, leadership styles could dramatically influence team functioning and experiences. The descriptions of leadership offered by the participants could be plotted along a continuum, with each leadership style significantly shaping teams in certain ways. Team functioning was directly and often profoundly influenced by these diverse leadership styles (See Figure 2).
Figure 2 – Types of Leadership Styles on PHCTs

The styles of leadership were composed of various features. At one end of the continuum were leaders who were experienced by team members as “approachable”, “accessible”, “available” and “open”. These teams were listened to, empowered and progressive. At the other end of the continuum were teams without a defined leader. These teams described feeling abandoned and “rudderless” which was manifested in team descriptions of being without guidance, goals and direction. In between these end points were teams who revealed autocratic and abusive leadership styles. Teams who were guided by autocratic leaders experienced firm guidance and clear direction; however, members identified feeling compromised in their own personal empowerment and autonomous functioning. Abusive leaders left their team members feeling injured and devalued. The abusiveness of the leader permeated team interactions and references to stress, tension and daily “coping” figured prominently. These four leadership styles and their implications to teamwork are described in greater depth.

**Approachable/Accessible Leaders: “We All Have a Say”**

Leaders who were approachable, accessible, open and involved with their teams were highly valued by their team members. These characteristics were also enhanced by prompt leadership responses and decision-making capacities. “His door is always open and he’s just
wonderful. Very open to new ideas and takes the lead on several issues. If there is a problem he deals with it promptly”. This leadership style encouraged team members to bring forward new ideas and innovations: “We’ve got really good senior management here that encourages people to come forward. You can talk to anybody and say “Let’s do this, let’s do that.” We’ve got mechanisms to bring that in.” Furthermore this leadership style understood how teams were not static and as such were continuously moving forward and responding to various circumstances and demands. This called for decision-making processes which responded to these external impingements. Decision-making for available and accessible leaders was constructed after much team input. One team leader explained:

I try not to make decisions unilaterally. We try as a group to make the decisions. Although I do still try to lead the team in a sense in that I will make a decision and say we are going to do this, but only after a lot of input.

Related to the needs of teams to be forward-moving and change oriented was how this style of leadership set a positive tone for change. Accessible and available leaders influenced change processes from the top down. Their encouragement was vital to how change was perceived, and how progress was accomplished. As one participant explained:

I think this place is quite open to new ideas. Some people may not want things to change but generally this is a progressive organization that does want to get going on things. This is lit from the top down. You have progressive people upstairs that encourage this, so then you find a way to get things done.

Approachable and accessible leaders were also highly skilled in empowering their staff to maximize their strengths and capacities on the team.

What I will say about [our leader] is he’s very open to what people want to talk about. If he feels it’s a social work role he’ll say “That’s your job, that’s great. You do what you think is appropriate and that’s good with me.” He oversees that. He
puts very few limitations on and he’s quite engaging in allowing us to be creative in our own professional area.

**Autocratic Leaders: “What I Say Goes”**

Leaders who were identified as having autocratic styles did lead their teams, but were not as open or as available to their team members. This style of leadership was present and prompt, but at the expense of the thoughts, ideas and feelings of the team. Autocratic leaders did not consider the views of others as intently in their decision-making and as such the implementation of change processes could be experienced as abrupt and jarring by the team.

This leadership style is reflected in the following quote:

*The last manager we had basically took the bull by the horns and said, “We’re going to implement this change and we’re going to do it and it’s going to start next week and this is how it going to work and we’re going to see how it goes.” That’s the way she worked.*

Depending on the organizational structure autocratic leaders could also overturn the decisions of those in subordinate middle-management positions. As one participant explained: *“We have a manager, but the medical director who is supposed to be overseeing medical issues overrides her. There has been a lot of conflict between the management and the directors.”* The outcome of this leadership style sometimes resulted in staff being disillusioned and left out of the “communication-loop”.

*At the end of my term [in management] I considered retirement more seriously because of the lack of respect…I’m just the middleman. I don’t know what the higher-ups are doing; they’re not going to give me the information.*

Participants caught in these managerial battles witnessed a challenge to middle management’s autonomous functioning. This was often experienced as disempowering to team members and sent a message of devaluing staff capacity.
**Abusive Leaders: “Do as I Say or Else”**

Participants who identified abusive leadership on their teams talked about avoiding their leaders, staying out of their way and described feeling “injured”. This style of leadership profoundly affected the team members in negative ways which ultimately permeated patient care interactions. “Some days everybody’s grumpy and it rubs off on the patients. They can tell. They say ‘she never smiles, … that grumpy one’, stuff like that. Patients talk.” Patients could observe the tension and abuse on the team.

*Patients can hear. We’re like fish in a fishbowl at that front desk. Patients are all around, they can all see what happens, they can all hear what happens. The doctor can come out with the chart in his hands yelling ‘Who put this patient in my office?!’ and ‘He’s not my patient!’ and ‘I’m not seeing them.’*

Teams who experienced abusive leadership were immobilized in their capacity to move forward in response to external demands. This leadership style poisoned the team environment such that employees focused on getting through the day. One participant offered the following perspective:

*He just thinks everybody needs to be at his beck and call…He’s number one and you’d better look after him. And when he asks you to do something, first of all you don’t give it to somebody else and you do it right then. Or you’ll hear about it.*

This abusive leadership style rippled throughout the whole team: “It just takes one nasty word, one bad mood and then it’s just all filtered down because everybody’s already stressed”. Also, abusive leadership had the potential to immobilize employees.

*And some just stay away from it. They don’t want to get involved. They just do their little job and they don’t get anything extra to do and they don’t want to have any confrontations and they don’t want to do anything extra and they just crawl in the corner and have a wonderful little day and then go home and come back the next day.*

Another example of how team members became immobilized was evidenced by one team’s interaction with their incoming telephone system.
There is a girl that sits at the back and cowers and doesn’t do anything. She sits there and the phone’s there, … and you can hear it and she will not answer it. She will not. And it’s going to ring off the wall.

A further manifestation of abusive leadership was how abusive behaviour of employees tended to ripple down the hierarchy of the team as the following quote illustrates:

... one of them [doctor] is having a bad day and miserable ... growling at everybody. It puts everybody in a bad mood. ... You just want to say ‘Relax, we are doing the best we can, it’s not a big deal, you’re making it into a big issue. So let’s just calm down and you don’t have to be like that.’ ... But he’s already caused that rift. ... [The negativity and the anger gets filtered down], filtered down and filtered around. Because someone yelled at me, I’m going to yell at you. And next is the patient.

The modeling of abusive leadership could set the tone for the acceptance of abusive behaviour as the norm. Subordinate employees began to incorporate this abusive style into their own behavioural patterns and transferred it down the line to other team members.

**Abandoning/Unavailable Leaders: “Who has a Say?”**

There were teams who identified a lack of leadership in their organizational structures which resulted in many challenges to the internal workings of the team. Leaders were unresponsive and unavailable to their team members or altogether non-existent. Team members were not able to bridge the chasm between their leaders and themselves. If leaders were physically present, they could not be “found” in meaningful ways. These leaderless teams were essentially “lost” in their own individualized roles and responses. They lacked communication that provided purpose and direction. As one participant in this situation stated: “Things go around and around and then you’ve got all this red tape and bureaucracy. Things take a long time to get summated for the most part”. Another participant expressed the impact of an “unavailable leader” on team functioning.
Our previous [leader] was not available...not a lot of direction was given to management positions and when there was no management position in place the information got filtered or it didn’t get through. There was not a lot of interaction with the clinical team...some of the information didn’t get passed on or when you needed the information it wasn’t available to you.

Here, these teams identify decision-making which goes “around and around”, getting lost in the bureaucracy of organizational structures. Changes took a long time to implement, and the team environment became compromised due to dysfunctional communication processes.

When leaders were not available or abandoned their teams, team environments became less cohesive and less focused on the goals they were trying to achieve. They were more challenged in the efforts to deliver quality services. As one team member offered:

*There is the captain of the plane who is the leader of the team and everybody in a hierarchal fashion falls below. The captain is ultimately responsible for navigating the plane and getting the passengers to their destination. When there is no hierarchy it operates as an anarchy.*

While the analogy to an anarchy may be somewhat overstated, it does suggest that team members without the influence of leadership were left to fend for themselves and reached their own conclusions. Similarly, one member suggested that problems inevitably result on leaderless teams.

*If you put a group of 15 people together and 3 of them thought they could run the pony show, and you didn’t identify which ones should, you’re going to have some problems. I think that a lot of problems in group efforts are the fact that there hasn’t been an assigned person to lead what’s happening.*

Teams who were impacted by abandoning or unavailable leaders lost their way. Team cohesiveness was highly compromised as was the ongoing motivation to remain focused in the goal of providing good patient care.
People were feeling, not lost but certainly that our focus, our team cohesiveness was really needing a boost...The key is a strong leader, a leader who will take an overall look and do some larger team building strategies for the organization.

Leadership remains a controversial issue as PHCT’s evolve. The findings provide direction regarding the role of leadership on PHCT’s and the impact of leadership styles on team functioning.

3.3.1.4 Accountability

Participants described several dimensions of accountability. The analysis revealed four broad dimensions of accountability: 1. accountability to patients; 2. physician accountability; 3. personal accountability and; 4. external accountability. All of the participants’ responses could be assigned to one of these four dimensions of accountability. Of these four, accountability to patients was an overarching theme which was ever-present and intersected with the other dimensions of accountability. This dimension was viewed as particularly important as it was mentioned across disciplines and by all team types.

Accountability to Patients

Participants’ responses illuminated a dedication to providing quality patient care. “I’m accountable to my clients first of all. When I make decisions about them I want to be sure that the decisions I’m making are in their best interest.” The concept of accountability to patients was not just specific to the individual practitioner but to all team members: “We’re accountable to the patient. We’re all accountable for the quality of care we give.”

Accountability to patients was also informed through a heightened sensitivity and empathy to the specific circumstances of patients.

I always say “What’s best for the patient?” so if we start getting off course then I would be the one who would say, “Alright what is best for the patient? If we had to,
or if the patient were our mother what would we want?” So let’s think about it in that way. Often that will bring us around to looking at it in a different way than we were looking at it before.

**Physician Accountability**

Family physicians described themselves as being ultimately accountable for patient care on primary healthcare teams and this was evident in all three types of teams. While many of the other professions who were part of these teams challenged this notion, family physicians themselves held strongly to the fact that they experienced themselves as the professional who was ultimately accountable. As one participant stated: “At the end of the day we as a group of physicians are accountable for anything that happens here.” They viewed this as their professional role and inherent responsibility: “Somebody has to take responsibility. That’s part of my role as the physician on the team.” In addition, they expressed how the “buck stops” with them, even in a CHC setting.

*I [physician] don’t have someone else I can turn to within the organization. The buck stops with me as far as clinical matters…Sometimes that’s a bit of a delicate path to walk, to try and stay on a level playing field. Everybody is even, but some are more even than others and I accept that. I don’t have a problem with that. I am well paid and well educated and well trained. Therefore I feel a greater sense of responsibility and accountability to make sure things happen.*

Their experience of being ultimately accountable was in some instances connected to concern regarding litigation: “The litigation stuff is way out of control.” Comments such as the following suggest how fears of litigation contribute to what could be argued as a detrimental team dynamic.

*We are always going to be practicing under that cloud of litigation...It is a huge cloud over interdisciplinary team practice. It is a huge cloud over medicine. As we try to practice together everybody is anxious about who’s going to get sued and when it is going to happened and who is going to be included in the suit.*
Noteworthy is how family physicians at Community Health Centers (CHCs) wrestled with the concept of shared accountability on multidisciplinary teams more often than physicians on types of teams in the study. These physicians still articulated a sense of greater accountability in comparison to other team members at the CHC.

*We’d like to think that we are working on a level playing field where we all mutually respect each other’s abilities and skills. I think as a physician I have the ultimate responsibility with clinical care issues, and so although I don’t see myself as being the boss or the leader, at a higher level than anyone else, I do think that when it comes to clinical decisions and clinical matters, I carry a greater responsibility than the other providers.*

However, the belief of shared accountability by other multidisciplinary members at CHC’s is evidenced in this quote:

*I have a hard time with the Doc having ultimate accountability because we all see the client. We all are accountable for what we say and decide is best for the client. It is true in terms of legal accountability that the doctor has the most. It’s a shame that this is dictating client care in some cases.*

As the previous quotes suggest, family physicians will continue to bear a greater share of accountability related to patient care in CHCs.

**Personal Accountability**

The second theme was a sense of personal accountability and was identified by most team members across all types of teams. Personal accountability reflected three domains: a) accountability to oneself for one’s job performance, actions and any personal errors; b) accountability to each other as team members and; c) accountability to one’s professional regulatory body or College.

Participants across all teams consistently identified personal accountability as an essential dimension of accountability in primary healthcare. Team members spoke about
each and every team member being accountable for their own job tasks and responsibilities.

“We’re accountable for our jobs...We all have to take responsibility for our actions.”

Personal accountability was deemed necessary to the overall functioning of the team, with participants describing the importance of personal accountability for overall healthy team functioning. Participants repeatedly identified:

Everyone’s accountable for their own actions in this office. I think there are some that are willing to be accountable and others that are not. But we all have jobs that we’re responsible for and we need to be accountable for them.

Personal accountability was also linked to the provision of quality patient care. “I think we have to all be accountable. We all do parts of patient care and the whole idea is to make it into one big package that gets your patients better.” Participants also described how to manage personal accountability when mistakes inevitably occurred.

In my perspective if you’ve made an error or you’re doing something incorrectly your best course of action is to admit that you’re not doing it correctly and figure out how to fix it and get it done. It is much easier to ask for forgiveness than it is to try and fire the blame off onto somebody else and cause a lot of unrest in the office and amongst the staff. It is just easier to deal with it that way.

Having team members who assumed personal responsibility for their job performance, actions, and for personal errors enhanced team functioning.

Participants across all the teams identified accountability to each other in the context of their professional relationships. This accountability provided necessary checks and balances against human error.

We are all accountable. If a physician makes an error, he’s accountable for that error. If I miss that error as well, then I go up the creek with him...there are double and triple checks in the system and we’re all part of that, those checks and balances so we have to all make sure that we’re taking responsibility so that we are all accountable if something goes wrong.
Being accountable to each other meant individuals had permission to ask questions of one another, as well as support each other in various ways which positively facilitated patient care.

Accountability to each other was identified across disciplines with a strong request from multi-disciplinary members for family physicians to heighten their recognition of the accountability assumed by team members in the provision of patient care. “I think we all have a commitment towards providing good healthcare, whether it’s the physicians or the nurses or even the support staff.” Participants also revealed a desire to move away from blaming one another, and rather move towards recognizing the professionalism and competence of all team members.

It is my responsibility to be as highly competent as I can be within my scope of practice so that I can enter the team in good faith, and not just good faith, that I present the least risk to that collaborative team as possible. I want to know that I’m presenting the least risk to my client too, but I want to know that I’m presenting the least risk to the other providers that I work with.

Accountability to each other is also exemplified in the following quote:

Let’s face it human error can happen anywhere. It happens in the pharmacy, it happens with the physicians, it happens with the nurses. We don’t want to get into blaming each other. That is something I really want to stress. What we want is for physicians to realize we do share their accountability and that is why it is all the more important that team members communicate with each other.

Participants identified accountability to each another as necessary for teamwork. They emphasized the need to move away from blaming stances. Non-physician members also identified a desire for enhanced recognition from family physicians for the accountability they share in the provision of patient care.
Participants across all the teams identified accountability to their own disciplines for professional registration and continuing education credits as important. Many participants also identified the importance of College registrations and affiliations as integral to their professional conduct and delineation of their scope of practice. “We all have own accountability within our own scope of practice. The doctor assumes that I am competent within my role too and that I am aware of what I can and cannot do within the Acts of the College.” This dimension of accountability was most often identified by participants at CHCs. This may be due to the higher number of nurse practitioners working at CHCs and reflect the heightened responsibility/liability these nurse practitioners now experienced. One nurse practitioner stated:

We are all accountable. We are accountable by the guidelines of our College. We work under certain guidelines, our professional ethics are very strong. We all understand and it is documented what these professional codes and accountabilities are...If it ever came back that there was a bad event...I am the one accountable, not the physician partner because I am the one that did it, it’s my license okay? We all work as a team, but really it’s your individual accountability as a practitioner.

It is evident from the responses, accountability to a discipline’s College assists in shared accountability for patient care with other multidisciplinary members of the team for the interventions these other members direct.

External Accountability

The final dimension of accountability identified by the participants related to external sources of influence and authority which governed or directly influenced the teams. Participants’ references to external accountability fell into three broad categories: a) fiscal accountability; b) accountability to the community and; c) accountability to hospital/boards of directors. These external sources of accountability varied across the three types of teams.
Fiscal accountability was more often identified as a dimension of accountability by participants working in FHNs/FHGs. This recognition of fiscal accountability may, in part, be due to an increased awareness and reliance on efficient business and fiscal practices in a fee-for-service model.

Frequently the office manager on these teams played a crucial role in the running of these small businesses with an enhanced status due to their close association with the financial dimensions of the practice. Their financial role also enhanced their status within the team as they became instrumental and key personnel who garnered a certain authority associated with their position. The physicians of FHG/FHN teams expressed appreciation for their office manager’s contributions in the vital day to day functioning of their practice. One physician stated: “Thankfully our office manager is accountable for the day to day business stuff.”

CHCs exclusively identified accountability to the community and how these teams are rooted in a community mandate and funded to respond to specific community needs. As one participant at a CHC explained:

*Our community expects that we’re going to provide quality programs and quality care. They expect that we’re going to provide meaningful programs and services for them. For example, if our community has identified air quality as the number one health issue, I’m not going to turn around and run a program on ingrown toenails because it isn’t going to mean anything to the community. My accountability with them is shot. I’m going to lose their trust and respect. Community is really number one.*

Accountability was shaped by the prevailing governance structures in which these teams were embedded. FPTU’s and CHC’s both identified this dimension of accountability. FPTU’s described complex reporting structures with multiple levels of accountability. As one FPTU participant explained this could be confusing and a challenge to navigate.
This is a complex environment where it is a matrix reporting structure. So in terms of accountability through the system this is the only place I’ve worked where I feel like I’m reporting to four or five people at one time. The hospital, the medical directors...you can have four or five people pushing you in various directions at the same time and sometimes what you have to do is go directly up the line in the hospital and get that person to give the bottom line, come back and report and even get them to come and sort out some of the issues that come up.

Participants at CHC’s described being accountable to their volunteer, community-based Board of Directors. “Everyone’s accountable to somebody and ultimately there is a Board of Directors whom everybody’s accountable to.” This was sometimes a structure which was difficult to engage with due to the voluntary nature of their Boards. A CHC participant stated:

*Your Board of Directors is supposed to know what’s going on and they’re supposed to hold the main strings so they really should be accountable. But they are a voluntary board. And volunteer boards...how can you make them accountable? It isn’t their job, they’re not getting paid to do it.*

Thus, four broad dimensions of accountability were identified: accountability to patients; physician accountability; personal accountability and; external accountability. Each dimension presented specific challenges to teamwork. In order to create, build and sustain PHCT in the future these challenges will need to be addressed and will require change not only on a team level but also within the broader healthcare system.

**3.3.1.5 Barriers to Conflict Resolution**

Conflict management and resolution is a key necessity for teams to work well. Participants identified a number of barriers to conflict resolution, which included: time and workload issues; people in less powerful positions; lack of recognition or motivation to address conflict; and not wanting to hurt other people’s feelings.
Time and Workload

Participants in busy practices with heavy workloads described a lack of time to deal with issues and conflicts as they arose. “Certainly time constraints can be a realistic barrier. You’re going to others for input or assistance and they have their own patient load or dealings at that time.” This lack of time was connected to a lack of opportunity to resolve conflicts and little time for communication, either informal or formal. As one participant explained:

... everybody seems to be overworked. And definitely a team barrier because we don’t always have time to communicate and, with everyday stress, it’s sort of difficult ... I think being overworked definitely leads to a lack of communication.

Lack of communication and opportunity created situations where some staff could be unaware of team issues in need of attention.

... we were just so busy that every day we’d just go, go, go, go...and time just flies by and we think we’re doing okay, we’re seeing the patients and everything’s happening. And then, at some point somebody will say ‘Well, things aren’t very good, we’re just really overwhelmed’. And it will be like ‘Huh? Where did this come from?’ And it’s like ‘what’s the problem? Why haven’t we dealt with this?’

Participants described the consequences of when relatively small or simple concerns were not addressed fully or promptly. “The workloads have gone up and they leave it so long that people get frustrated and I think that causes conflict within the workplace.” The issue would become larger and more complex, leading to frustration and greater conflict on the team.

It could be that it’s not as urgent an issue at that time. Things just sort of build up over a period of time and...if things continue to happen, then all of a sudden [it] comes to a head and blows.
If situations were not resolved promptly, conflict-resolving decisions could become autocratic and not participatory.

_The other issue that gets in the road is time. Sometimes you’ve got patients waiting in the waiting room and you don’t want to take a lot of time to resolve something. So sometimes you take the quick answer and go ‘You could just do it like this in the future, that would work a lot better’, instead of taking the time to go through it, and giving them more of an opportunity for input._

Finally, busy workloads and lack of time limited the opportunities to deal with issues in a timely manner and became barriers to conflict resolution because of the extra effort required.

_Well, some of the barriers [are related to] overlapping time with that individual. So if it’s a big conflict and you’re not necessarily on at the same time with that person, you’d have to take extra steps, to conflict resolution._

**People in Less Powerful Positions**

Issues of power, leadership and authority could not only fuel conflict, but hinder resolution, regardless of practice setting. Participants described feeling intimidated, resentful, and fearful of consequences. These feelings became a barrier to communication, which should have alerted those in leadership positions to act.

_Well, sometimes I think the team members feel like they’re not being heard. So they may complain about a situation and nothing happens. And then they become very frustrated and either they swallow it, and then just ignore it. It’s not a very good solution._

But more often, those in authority were the focus of resentment, furthering feelings of intimidation and lack of control.

_There’s kind of a hierarchy we talked about before that the ones that have the power have ultimately the responsibility. So if you disagree with a physician and that physician feels that he or she is right, you’re not going to, it’s going to be a problem to try and change that doctor._
The inactivity on the part of those in leadership positions revealed a resistance to change and lack of motivation to resolve conflicts.

*I wouldn’t say anybody is openly confrontational, it’s a bit passive in the sense that they will hear you out and then not take any action. Hear about your needs, rationally counter everything you say and then not take any action or listen or follow through. And so on the surface it looks like respectful listening, but there’s very little follow through or action taken.*

**Not Valuing the Conflict – A Lack of Motivation to Resolve**

When the impact of conflict was not obvious, especially to those in leadership positions, a lack of motivation to resolve conflict could result. One doctor described:

*... having difficulty putting a value to what is a conflict or a source of stress to someone else. It sounds bad coming from a doctor, but you’re working and something that seems a little bit irrelevant to you at that time, you just don’t seem to want to be bothered by it. A big barrier is not valuing the distress that that brings to somebody.*

Most often, however, participants described situations where one team member was unwilling to address a conflict with another, or simply “*the other person doesn’t think there’s a problem.*”

*The barriers would be when you have somebody who’s not willing to listen ...when you have somebody within themselves [who don’t] see that they aren’t willing to listen and change. ... It’s very obvious and it’s uncomfortable and it’s awkward and it’s unfortunate. I’m not in a position really to make it better.*

Lack of motivation to resolve conflict could take a number of forms. Some team members simply avoided anything confrontational, as described by one participant:

*I guess if you don’t address it, if you just ignore it. If there’s a conflict and two people stop talking to each other and everyone just ignores it.” You see that happen and you say ‘Gee, they don’t seem to be very nice to each other’, and no one says ‘What’s going on? Why aren’t you talking to each other?*
Other participants described “Avoiding and gossiping ... I think there’s a fair bit of that.”, or cliques of team members resulting when conflicts among staff were not addressed:

*I think that we had gotten into patterns over the years, of not confronting, tucking stuff down in, and then nattering into little groups. So forming little groups of unhappy people. So you’d [have] a meeting, you’d present an issue, people wouldn’t talk about it or they’d come out with one conclusion from the meeting and they’d go into their little group and have another discussion. And then it would come back and there would be no resolution. ... Some people hate conflict. They love to talk about stuff, but they hate conflict. Or they hate confrontation.*

Participants suggested several reasons why conflict resolution might not be valued. Staff who were unaware of a shared philosophy of patient care or who had a different style of practice might not be motivated to address conflict around this. As one participant observed

*I think it’s because the particular person that is causing some conflict on the team doesn’t have the same appreciation for, or doesn’t have the understanding, or doesn’t want to understand what the concept of our patient delivery model is.*

Resistance and lack of motivation to address conflict was also attributed to differing personalities of team members. Some team members were “Not comfortable with conflict, so they don’t want to verbalize it. Some people can’t face it and so they won’t talk about it or come to some resolution.” Other team members, with "strong personalities" would “stand in the way. Somebody won’t budge on something.” Defensiveness and anger were also personality traits mentioned by participants. As one participant described, when team members were defensive,

*And so you don’t want to confront them initially. Some people are really defensive. And so if you approach one issue and have gotten a really defensive response, you’re less apt to want to approach it the second time...So it has to do with personalities and how people accept criticism or suggestions for change. I think that’s probably the biggest barrier.*

However, when team members reacted with anger, consequences were different.
I think sometimes people don’t know how to do it. They don’t know how to say it. And so sometimes people have to get really, really upset before all of the sudden they explode. ... So I think it’s a case of they don’t know how to express themselves in a way that’s not offensive to other people.

Don’t Want to Hurt People’s Feelings

Another major barrier to conflict resolution was not wanting to offend or hurt colleagues feelings. Participants’ related this barrier to a sense of working in close proximity and seeing fellow team members for many hours every day.

We work in a really close environment in here and if you’re having differences with one particular person, it makes it very difficult for everybody else because the tension is there. So I think that if there is any barrier, it would be that you don’t want to hurt someone’s feelings so you let things ride maybe just because it’s easier to do that.

Not wanting to hurt a fellow colleague’s feelings could impact on annual performance reviews and as such limit their value in improving teamwork.

...because it is between peer and giving negative feedback is probably one of the soft spots of that particular way of doing performance reviews. And it’s just hard to give. So it’s couched very nicely and as a very, very positive thing. So it gets talked about that way. Does it get talked about in other ways? Kind of, but not, I don’t think openly. I don’t think we have open conversations about what isn’t working. ... I guess it has to do with whether there’s strength of feeling there ... if there’s a lot of emotional intensity about it, we do not do well with that in the team.

Participants also identified how friendship or experiencing the team as family could be a barrier when needing to confront conflict.

We are kind of like a family so it is tough sometimes to deal with things on a more strictly professional basis. It’s kind of a double edged sword. You want to encourage good morale, but it sometimes acts as a barrier when you have to, basically, enforce professional rules. So I think that’s a barrier.

Another participant explained that this can be a challenge for teams with these feelings,
“...it’s like the white elephant in the room, nobody wants to be too vocal about it because nobody wants to hurt anybody’s feelings.” However, viewing team members as friends or family is a positive attribute of teams that work well, and as such “the friendship is also a strength” which can be used to resolve conflict and thus preserves those positive feelings.

As indicated above, several internal challenges to teamwork emerged from the data. These included: team composition, roles and scope of practice; leadership; accountability; and conflict resolution. In addition to these challenges, participants described a number of external challenges with originated outside PHCTs.

### 3.3.1.6 External Challenges to Teamwork

Participants identified four key external challenges to PHCTs currently in Ontario which included: a lack of health human resources; patient expectations; resources and commodities (i.e. time, funding needs, and physical work environments) and; access and wait times. These are not presented in order of priority or urgency but rather need to be viewed from a systemic or interactional perspective.

**Health Human Resources**

The first external challenge was a lack of available health human resources. Many participants emphasized the shortage of family physicians. “We have a huge shortage of physicians.” Participants also expressed their deep concerns regarding the lack of healthcare professionals to provide primary healthcare.

There’s only so many hours in the day and we’re so short of doctors in this area that it’s just crazy here all the time, it’s busy...You can’t give your patients as much time as you would like to, doctors, nurses, everybody,...I think on the whole we do a good job. We do the best we can with what we have.

Connected to the paucity of health human resources was the stress of patient volumes. “Just the patient volume here. It’s just too much. There’s not enough time.” There was also a
feeling of not being able to adequately address patient needs. “There are so many patients...and there are only so many hours in the day.” Another participant stated: “The biggest issue is we just do not have the resources. There are just not enough physicians to actually care for all of the people that actually need to be cared for and so that’s the problem I think.”

Patient Expectations

The second external challenge to PHC teamwork was the unrealistic expectations of patients. Participants perceived patients as expecting immediate and convenient care.

...The patients just expect that it’s their right to get in at any time, no matter what, expect to be seen instantly, and at no cost...It isn’t going to be that way forever...you can’t have a system where they have no responsibility for their use of the system...

Some patients were described by participants as demanding and sometimes hostile. As one participant succinctly stated: “Some of them are simply obnoxious and rude.” Another participant explained:

I find the challenge is really just the patients are quite angry and I find with the healthcare system now they tend to take it or put the blame [on us]. We’re busy, we’re in an underserviced area and we’re trying to do the best we can.

Frontline workers often felt overwhelmed by patient expectations: “some patients can drive you to tears, because they are so demanding.” Healthcare professionals felt unappreciated for their efforts and hard work as one participant eloquently expressed her feelings on this issue:

I don’t think people realize that there’s a shortage. I don’t think they realize that your physician is working 10 times harder than they should be. Like their practices are huge. They can only do so much in a day. And people have no understanding of the fact that my doctors want to go home and spend time with their families.
Resources and Commodities

The third external challenge to teamwork expressed by participants was limited resources and commodities, specifically a lack of time, funding needs and inadequate physical work environments. Lack of time was identified by participants as one of the greatest external challenges faced by PHCTs. “There’s just not enough time in a day to see everybody who needs to be seen.” In relation to the issue of time, a participant articulated this dilemma:

Time – that’s the biggest thing. There is not enough time to talk, not enough time to problem solve, not enough time to work on solutions. I call it the wall of work – we come in the morning… and you hit this wall of work and it just comes over you like a steam roller.

Lack of time also impacted team functioning: “To be able to manage teams with respect often takes time. There is never enough”. Participants repeatedly stressed inadequate funding as a major challenge. “Money is always the biggest one. We don’t have enough resources to do what we need to do to make sure that clients are okay.” Another participant, who captured the concerns of many study participants, stated how fiscal restraints impacted team functioning. This quote also highlights the impact on teams when their physical work environment is less than optimal.

If I was to say one thing it would be money. There is not enough money for equipment, there is not enough money for new furniture in the exam rooms. The technical equipment is old and archaic and it doesn’t work right. So this lack of money means more stress on the staff which means things aren’t going to function as they should which means the team is not going to function... And it just continues and it’s a downward spiral.
Inadequate space could be a challenge to communication on the team. “Space is sometimes another issue that can also affect how teams work. If people are scattered all over the place it can make it very challenging for communication.” For CHC’s in particular, the issue of having more than one site was a challenge to teamwork and team cohesion.

We are quite separate because we’re in a separate building, and that makes it a lot more difficult. We do have some staff at our other site that work in what are called dual positions where they will attend our meeting as well as the clinical meeting…having the 2 sites makes it a lot more difficult…I guess the biggest challenge is the distance in the two locations.

Access and Waitlists

The fourth external challenge was the issue of access and waitlists. Access to specialists and services and dealing with long wait times placed stress on primary healthcare teams. “Waiting lists are a barrier to the team accessing other supports and services.” They felt frustrated by their inability to secure services for their patients in a timely fashion. The following quotes serve as an illustration of this external challenge. One receptionist described her frustration in trying to access services for patients. “It’s frustrating for us because we’ve tried and we can’t seem to go anywhere…it’s like treading water with a 10 pound weight attached to your foot.” A doctor described his regret in not being able to secure services for a very needy group of patients. “Last year I had a group of 4 or 5 patients with cancers that were not curable. They really could have used some palliative treatment. They died before they even got in there [weeping].” Another participant expressed concerns regarding the time required to access referrals and how the wait times were frustrating for providers and patients.

...it takes a lot more time now to do all of the referrals. Sometimes it can take 5, 6 months before I even get an answer to a request I’ve had for an appointment and then
they might wait another 6 months. These are really frustrating. I might spend an hour sometimes trying to find a consultant that will see somebody urgently because that’s just not good enough to wait a year for somebody who has a real problem right now.

Thus, teams experienced several external challenges including human resources, patient expectations, resources and commodities, and access to waitlists. Participants, however, could also readily identify solutions to many of the internal and external challenges they experienced.

3.4 Solutions

In addition to the internal and external challenges to teamwork, participants also provided both practical, as well as innovative, solutions and recommendations to enact change. These included: public education and increased patient accountability; secure funding mechanisms; optimal physical work environments and; means and mechanisms to assist in creating, building and sustaining teams. The latter included team development and sustaining activities as well as mechanisms for communication.

3.4.1 Public Education and Patient Accountability

Participants expressed a need for increased education of the public in order to address unrealistic expectations and to alter the current mindset of “immediate service”. As one participant explained:

*I think there needs to be a little bit of education in the public sector just so that they realize that things aren’t immediate. You might not get in to see doctor the same day and sometimes you can deal with some of your own problems.*
As the previous quote explains, patient accountability within the context of healthcare must be addressed. As one participant succinctly stated: “Patients need to be more accountable.”

Another participant elaborated on potential solutions to this issue.

> People just don’t seem to be able to do any of their own care or look after themselves. There’s some people out there of course that do but there’s a lot of people out there that have a lack of knowledge to basic. I don’t even know if I want to call it medical care. It’s just personal care even in the workplace if there could be more training on how to lift things prior to someone lifting something and getting a back problem...how to take a pill and how to read a pharmacy script that’s on their bottle whether they need to see a doctor or not, those kinds of things.

Another participant addressed the lack of concordance between patient expectations and those of the government. Furthermore this quote encapsulates how the central issue of accountability must be addressed at multiple levels within the healthcare system.

> Huge one is the expectations of the public and the expectations of the financial body that finances it. Very different. And they’re irreconcilably different in my view because there’s the huge problem of personal accountability. It doesn’t enter the equation at either end. And that’s a real problem. We’re never going to get rationalization of healthcare as long as it’s perceived by the public to be free because then it has no value. The external problems are the government can’t afford it unless they can introduce accountability and the only place they can introduce accountability that’s going to make a difference is at the patient end...So there’s a huge disconnect between what the patient perceives as his right and what the government perceives as the need of the government to provide for the care and manage the costs.

### 3.4.2 Secure Funding Mechanisms

The importance of securing funding mechanisms was strongly suggested by participants and was deemed a necessity to create, build and sustain primary healthcare teams. The issue of funding permeated multiple levels and had implications for future team structures. As one participant stated:

> More money. I bet every facility here that you talk to is in the same financial constraints we’re under, that’s probably one of the stress problems that we have and
again we have that added stress level that these are community dollars so if we have a shortfall it’s community dollars that are supporting this.

Another participant explained how additional funding would allow the team to expand and extend their capacity to meet patient needs:

Money is a huge issue. We’re thinking of becoming a family health team. Getting some extra funding might mean that we could get extra members on our team like a social worker would be great and a dietician, especially with our population.

Participants spoke about the pervasive anxiety regarding future funding. The following quote captures the stress experienced when teams felt financially vulnerable. This supports the need to provide secure funding to ensure team functioning.

A big one is funding. If you’re always worried that your funding’s going to be cut and somebody’s going to lose their job then that’s going to make the team have a difficult time working together. Because it just causes stress in that team members will feel uncomfortable dealing with those other teams members that may lose their job, or their job may be affected in certain ways.

In addition, participants identified the need to adequately remunerate all members of the team. As one participant explained: “I think family physicians should be better paid and there should be more of them. Their services should be more valued by the provincial government”. Not only were staff underpaid and required improved compensation but often there was insufficient personnel to meet work demands.

More money. I mean the ability to hire more staff to do the work. Our nurses are overwhelmed, they’re giving more than what they’re paid for. There’s just so much work for them and there’s no money to pay them.

One participant summarized the need for secure financing mechanisms. “It comes down to the available resources in order to support what it is that we’re saying we should all be doing.”
3.4.3 Optimal Physical Work Environment

Related to funding was the need to develop an optimal physical work environment to facilitate teamwork. A work environment which promotes communication and provides opportunities for cross-fertilization of knowledge and practice skills is a basic necessity for teamwork. The outcome is not only stronger teams but also improved patient care. Hence, participants strongly recommended solutions to address cramped work environments. As one participant lamented: “On a busy clinic day we have the carts with the charts there [in the hallway] when it gets hectic. You’re tripping over each other, you’re tripping over the desk, you’re tripping over the cart.” Clearly, a more efficient work environment is needed. Another participant commented on the effect of a suboptimal environment on communication.

There are so many people in that room. It’s a room about this size [small] and when I’m there there’s probably around 6 people who use it...you can’t possibly be confrontational in a helpful way with the person [who is] struggling. Everything they say everybody else is listening to. It’s just awful.

Some participants made very specific recommendations for changing their work environment.

Getting enough funding for instance like we do need more room here. We need renovations to be done and I feel that they are put on hold because of lack of funding. It’s kind of exacerbating the stress that might be present in certain interdisciplinary groups.

3.4.4 Methods and Means to Build and Sustain Teams

Participants clearly expressed a need for methods and means to create, build and sustain teams. Two main areas received attention: team development and sustaining activities and mechanisms for communication. Before exploring these in detail, perhaps one
of the most salient messages from the participants is captured in the following quote describing how teams are not created through forced collaboration but are based on relationship building.

...hiring social workers and PTs and OTs and pharmacists does not make an interdisciplinary team. It means you have a lot of different people working in the same office. I think you have to look at how you work in a truly interdisciplinary way...And that doesn’t happen without a lot of thought and discussion.

3.4.4.1 Team development and sustaining activities

Three key themes emerged regarding the role played by sustaining activities in facilitating teamwork, and were categorized as follows: 1. professional and business activities; 2. social activities; and 3. sharing life events.

3.4.4.2 Professional and business activities

Participants identified specific professional and business activities as sustaining teams and included: attending formal meetings, participating in professional development programs, and participation in retreats for the purpose of team building.

Participants believed that “a formal team meeting is vital”. Furthermore, formal team meetings were perceived as a means to build rapport and enhance communication:

Team meetings are a good way to sustain the team because you can build a general rapport among everyone. Informally when you communicate in the hallway you can do that, but you don’t have the chance to meet with everyone at a regular, convenient time. I think it makes a difference.

Regular team meetings provided a venue to share ideas and concerns, even the mundane.

I believe that the staff should have a forum, because where do they bring their concerns? We’re always too busy to approach with what they might think is mundane, such as who’s going to call to get the doorknob changed?
Finally, formal team meetings provided team building opportunities: “The meetings every week are team building as well as the monthly meetings with the entire team. I think that is how we help to build a stronger team.”

Participants viewed professional development activities as an important means to sustain the team. Such activities could include attending a seminar to acquire new knowledge and could also serve as a social time. “Recently several of us went to an immunization seminar ... We went as a group and it was good. It was a social time for us and we were learning something.” Opportunities to share information with the rest of the team after attending a conference or workshop was also viewed as a team building activity. “People go to conferences and then they report back. For example, our staff team meeting next week is where everyone comes back and presents back what they’ve learned. So there is some sharing in that way.” Furthermore, participants described professional development activities which assisted in addressing problems identified in team functioning such as communication.

We had a whole day workshop back about two years ago because we seemed to be having problems with communication .... The messages between the nurses and the front desk weren’t getting back and forth and it was just a breakdown of communication. So the workshop reminded people that you don’t make assumptions.

Participants also identified how “in house” educational activities or collectively attending a conference were team building experiences.

I think team building takes time. And I guess we’re pretty lucky that we work here together and we can utilize a noon hour to have a meeting or have a function or bring in a speaker that can facilitate that team building. I think if you can send a group of people to a professional development conference that often helps with team building.
Conversely when professional development activities were not supported, this had an impact on team morale as revealed in the following quote: “...if I wanted to take a course, that’s up to me. They don’t, they don’t force it on us, they don’t offer it to us ... but if we could all go to these things together. But it won’t happen.”

For those participants who had an opportunity to participate in a retreat as an entire team the experience was highly valued.

The CHC actually does an annual retreat for us and so we get a chance to talk about what our programming, our ideas going into the future, or what we’ve been doing in the past, what seems to be working, what isn’t.

However, due to time and fiscal restraints many teams, FHGs/FHNs and FPTUs in particular, no longer had retreats. “We used to have annual retreats. They were wonderful. Unfortunately our person-power has decreased around here and financially it’s caused some hardship so we haven’t been able to do that.” There appeared to be a sense of a disappointment regarding the loss of this sustaining activity and little hope of it being re-instated.

It would be nice if we could afford to have our retreats again. It would be nice if we could afford to send our team members on educational outings ...something that’s enjoyable but educational at the same time. But we don’t feel we have the resources for that.

Even if annual retreats were not possible opportunities to come together as a team and increase awareness of each others’ knowledge and skills was viewed as important to team building and patient care.

I think any team should have a time when they can get together and just know each other and feel comfortable with each other and each other’s knowledge. And that probably should happen on probably a quarterly basis, so that they could work together more effectively for the patient. There just isn’t time to always to do that or
not attention paid to that. You know at the medical centre they would have lunches and that sort of thing, but people would get busy and they wouldn’t attend ... for team building, everybody needs to be there.

Time and funding were again raised as issues of concern in implementing team building activities. Time was required to establish the basic building blocks of a team, in essence the pillars of teamwork. A participant succinctly captured this perspective: “I think you need to carve out more time to work on the whole teambuilding thing.” Another participant articulated the need for increased time dedicated to team building.

If anything we don’t have enough time to sort of work together really because you know it’s really, really busy so you know our team meetings get pretty crammed with boom, boom, boom and we don’t have as much time for the reflection that we’d like to have.

In relation to funds needed to support team development a participant aptly stated:

I think that we need to have funding and resources to help us learn to develop teams. It’s very, very unlikely that even with the best of intent that teams will actually get up and function independently by throwing people into a box and shaking it up.

3.4.4.3 Social activities

Social activities fostered team cohesion, professional connections, and were fun. Social activities were used to accent changes in team composition such as retirements: “Well retirements, we always make sure that we have a party and give them some kind of substantial gift for the time they’ve invested with us.” Also, seasonal events such as the annual Christmas party promoted camaraderie, laughter and a chance to get to know each other on a personal level.

At the Christmas party it always involves some kind of silly game, that gets everybody involved and it’s always fun. We go bowling in the dark. We have a gift exchange where I can take your gift if I think I’d like it better. We try to find situations where we laugh.
Other seasonal events such as the “annual summer barbeque” served to enhance teamwork through extending worker appreciation and promoting staff motivation.

*We have a get together in the summer. We’ll barbeque at somebody’s house. The doctors will host it just to let the staff know that they appreciate what we do and it keeps us motivated in wanting to please them as well. Knowing that you’re appreciated makes you want to work hard for them.*

Several teams spoke of the “*Friday night happy hour*” as a time to unwind, debrief about the week and have a social exchange.

*Friday nights we have happy hour and keep wine and beer in the fridge. It’s the social stuff… have a glass of wine and everybody talks about the tough things of the week or how we could have done things better, and what’s going on in our lives. It helps in team building.*

Finally, there were daily activities that sustained the team such as ordering Tim Horton’s coffee.

*One of us will always buy treats at Tim’s once a week. We did it yesterday. We’re doing it today. Some weeks we’ll go a week and we won’t do it at all and then all of a sudden the docs will get in the mood and they’ll fling a $20 at us and say, ‘I think we need coffees today.’ Well that’s good for morale.*

### 3.4.4.4 Sharing life events

Sharing life events could be either of a celebratory nature or a time to grieve losses together. Participants described how celebrating life events such as birthdays, marriages and births, sustained the team and created a family atmosphere.

*One of the girls is getting married next week so we will get together and have a shower for her. We’re pretty close in that aspect. If somebody has a baby, the doctors are very good at giving presents and remembering. Everyone has a birthday*
and we have a birthday cake. It’s just part of your family. We’ve worked here that long. I just feel like I have my family.

While the following quote reflects the celebration of lifecycle milestones, participants also spoke of the value of knowing one another on a personal level which was both personally validating and teambuilding.

... meeting each other’s partners, families, we all know each other’s children. Again helps with conversation, ‘How are your kids doing? What are they doing?’ And I think that also makes people feel validated and important and like being part of the team. Rather than just somebody who comes and does their job and leaves.

Finally, grieving life events together as a team was seen as supportive and sustaining. “We have had people who have gone through deaths of parents, divorces, illnesses and there is a great deal of support.” On several teams participants had experienced the terminal illness and subsequent death of a valued team member. They shared their remarkable stories of how the team had supported each other during these difficult experiences and how it had brought them closer together.

One of our staff members was dying and all of us were involved because she was also a patient at the clinic and I think the way we dealt with that was by mutual understanding that we were all feeling the same way.

Social activities and sharing life events are sustaining activities created and maintained by each individual team as they develop their unique routines and rituals. All teams have the capacity to institute these sustaining activities and need to acknowledge the important function of sustaining activities in overall teambuilding. Professional and business activities are often limited by fiscal restraints and their important role in teambuilding needs greater emphasis when considering allocation of funding for primary healthcare teams.
3.4.4.5 Mechanisms for Communication

Four themes emerged from the data regarding the means and mechanisms used to communicate on primary healthcare teams. These included: (1) formal communication (i.e. team meetings, agendas, meeting minutes and memos, computer assisted communication, communication logs, and performance reviews); (2) informal communication (i.e. hallway consultations/chats and sticky notes); (3) attributes which facilitated both formal and informal communication (i.e. approachability, availability, accessibility, proximity, and relationships); and (4) funding issues.

However, before presenting these three key areas of communication we acknowledge a perspective noted by many of the participants that methods of communication reflect each team member’s individual style or preferences of communication.

"Each of us has our own style of communication. Some of us still like to have sticky notes on the charts; some of us prefer to have the computer with the flashing message light telling us that there’s something that we should be attending."

3.4.4.6 Formal Communication

Team meetings were viewed by participants as fundamental in their formal communication process and an opportunity to engage all members in a consensus building process.

"At team meetings we discuss problems or things that we think need to be addressed. Everyone puts in their two cents regarding the problem. We operate on consensus and solve issues and make sure that everybody is okay with the decision that is made."

Having team meetings that were both regular and scheduled was also seen as important.

Regularly scheduled team meetings provided a venue to discuss issues relevant to the team and to problem solve about clinical and administrative issues.
If there’s something that needs to be instituted or brought in practice-wide we’ll do it through those meetings and then we’ll send minutes of the meeting so that everyone is aware of what was discussed because not everyone can attend.

Participants also commented on how agendas and minutes of team meetings assisted in organizing and documenting the team’s activities and decisions. “I make an agenda ahead of our discussions of what everyone’s concerns may be and we voice our opinions and try to work things out for ourselves.” Minutes taken at meetings served as documentation and guided the direction of future action. “At the monthly meetings there are minutes taken and referred to over the course of the following weeks.” Memos served as another means of communication amongst team members to relay urgent messages. “If there was something urgent I would send a memo.” or to provide updates “The doctors send a lot of memos. They send them to every team member about something in public health or current issues that are happening.”

Although computer assisted communication is relatively new to PHCT, it was endorsed by the majority of participants. They saw it as a more efficient means of communication and less vulnerable to human error.

The computers have become a really good communication device because it has a messaging system on the EMR. So instead of having a whole bunch of little slips of paper with messages on it, which sometimes get lost, they’re listed in the computers ... You don’t have to worry about where you put the piece of paper.

Computer assisted communication was also viewed as a more prompt means of sharing information: “With our computer system we have a wonderful message system where we can relay the messages and ask questions and then they reply that way.”
However, participants spoke frankly about the pros and cons of email communication. Major positives for email communication were transparent documentation, efficiency and objectivity: “It has to do with documentation and making sure that it is in writing and in some instances it is more time efficient and it keeps the emotional aspects out of it.” On the other hand several constraints with regard to email use were voiced by frontline staff:

“We’re front line so computer access for email is quite restricted. You seldom have time to sit and read a full email … so, emails for me are failing us as secretaries. Doctors and nurses can shut their door in between clients. We don’t have enough time.

While these individuals had limited time to check their email they relied on the tried and true “grapevine communication” to alert others to essential email messages. “But we don’t always have time to check our emails …. so what happens is one person will see it and then pass it to the rest and then everybody’s checking their emails.” Finally, there were those on the team who were “not computer savvy” or were perceived as being “afraid of the computer” and “Not tenacious enough to figure it out” as they did not view it as “a priority”.

Another important form of formal communication, which was more profession specific, was the use of “communication logs” to transmit information about patient care issues. Communication logs were essential where team members held part-time positions or were job-sharing and rarely had face-to-face contact. “The nurses keep a log book so that we can jot things down and communicate important information to the nurses who are not here every day. That way nothing gets missed.”
Finally, annual staff performance reviews were mentioned by some participants as a means of formally recognizing employees and communicating appreciation for their work effort.

Too often no one says you’re doing a good job, you’re doing well, you’ve been with us a long time and you need a pat on the back that says ‘Wow you’re doing a great job again this year!’ You don’t hear that if you don’t take the time to evaluate your employees. That is so important.

Annual performance reviews also provided employees with a forum to communicate their interests or concerns in relation to the work environment and their own personal performance.

3.4.4.7 Informal Communication

Informal communication was described by participants as the most prominent method of sharing and transferring information about patient care. In contrast, formal communication methods were more related to administrative, policy or business matters relevant to the team. Thus, on a day to day basis “hallway” consultations and chats prevailed: “Mostly I used face to face communication. I find the person I want to speak to and talk to them directly.” For patient care, face to face verbal communication was the preference: “I’m verbal. We can use the computer, but it’s just easier to verbally pass information back and forth.”

When face to face communication was not possible “Sticky Notes” became the medium of communication: “Say a doctor is in with a patient, we’ll just stick a note on the door and say – come see us ... this has to be done.” As one participant described there could be a plethora “sticky notes” on a given day: “Little notes attached to the computer or here,
there and everywhere.” Another participant stated: “The sticky notes, they’re my lifesaver!”

3.4.4.8 Team Attributes Facilitating Communication

Participants identified specific attributes that facilitated communication in PHCTs including: approachability, availability, accessibility, proximity, and relationship building. Each attribute was interwoven with the other and served to foster both formal and informal means of communication within the PHCTs.

Approachability reflected team members’ comfort and ease in communicating with other members of the team. “If something is urgent that I want immediate action on, I find them and talk to the person .... Everybody’s very approachable and you can talk to anybody any time.” The attribute of availability was often assigned to team members with more power or seniority. “My door’s always open and there’s always someone coming in and chatting about something.” Accessibility was described as proximity to one’s colleague: “We sit across from each other so she would basically tell me if she thought there was something I should know.” Through this proximity communication was facilitated:

We share an office, so we’re talking constantly, there’s lots of back and forth to the front of the office, and the staff are in and out of our office ... catching us between patients and saying I need to talk to you for a second, so there’s that verbal kind of communication.

Finally, through ongoing communication relationships were built and sustained. “We communicate a lot ... on a daily basis. We all get along really great here so we’re always communicating.”
3.4.4.9 Funding Issues

As in several of the solutions offered by participants, there were funding issues related to communication. For example, participants expressed an interest in becoming more computerized to improve communication but were limited by finances. “To go to a paperless office would be great but we don’t have the funding for that.” Funded team meetings to promote communication and improve patient care were suggested by participants. These meetings would provide a venue for discussion and transfer of information about patient care and administrative issues. Such meetings would also promote team building by reinforcing the pillars of teamwork and enhancing the characteristics of good teamwork. As one participant stated:

If anything we don’t have enough time to sort of work together. Because it’s really busy so our team meetings are pretty much crammed and we don’t have as much time for the reflection that we like to have. We’ve just got to get through this huge list of stuff we’ve got to get through in the next hour and half or so.

Therefore, participants perceived several possible solutions to rectify and circumvent challenges to teamwork. In particular, public education and patient accountability, secure funding mechanisms, optimal physical work environments, and the methods and means of building and sustaining teams were highlighted.

In addition to highlighting the challenges and solutions to teamwork, this project aimed to explore topics of prevention and health promotion across PHCTs. The following section provides an overview of prevention and health promotion initiatives in PHCTs as well as community services frequently described by participants.
3.5 Prevention and Health Promotion Activities of PHCTs

Participants were asked to describe their team’s prevention and health promotion initiatives. In addition they were asked to describe what community services they utilized. Please note the numbers presented in Tables 5 and 6 may not reflect all the prevention and health promotion activities these teams are currently providing nor represent all the community services to whom they refer. This information was collected during a discussion with the participants and did not utilize a survey tool or checklist. Therefore, participants may have simply not offered a comprehensive list of all their activities. The most frequently mentioned prevention and health promotion activities are shown in Table 5 and reflects the diversity of activities provided by PHCTs. Across all 16 teams, immunizations, smoking cessation activities, prevention screening, care for nursing moms, flu clinics and patient education activities were mentioned by more than half of the teams. Participants described their teams as generally positive and open in their approaches to prevention and health promotion. As one participant described:

_We have a very wide range of things that we approach here, but certainly we try different things when they come down. We are very open minded. And usually there’s always one of us that says ‘this is a good idea, can we try it?’ and the rest of us will say ‘yes,’ generally for promotion of health._

Participants from five of the seven FHG/FHN teams described immunizations, preventive screening, care for nursing moms and using posters and pamphlets as part of their prevention and health promotion activities, as did majority of FPTU teams, with the addition of flu clinics, smoking cessation activities and use of TV/video. Time and busy workloads were two barriers to health promotion and prevention activities mentioned by participants in FHG/FHNs and FPTUs, although participants also observed that such activities were “just
done so automatic[ally] ... we’re doing it all the time”. Nurses in these practices were credited with doing the majority of activities, whether it was “fielding questions over the phone, talking about flu shots, talking about baby immunizations”, “educating young mothers, baby care, a lot of counseling”, or “a bit of teaching”. Family physicians, and occasionally office staff, were also mentioned as being involved in prevention and health promotion activities. “The nurse does a lot but I think it is reinforced by the doctor as well.”

Participants from all five CHCs presented a different perspective, describing a wide range of other services provided ‘in-house’ through their health promotion teams. These included a wide range of services for which FHG/FHNs and FPTUs may refer their clients to community services (Table 6). As one CHC participant described:

So there’s a number of programs that are going on here at the centre. If someone for instance comes in and wants to lose weight, well we have a program that they can do right here in-house with us. Because we’ve got a multidisciplinary team right here on site ... it makes our team work easier. ... you pick up the phone and you’re talking to someone who’s in house with us, as opposed to doing all your referrals out of house. ... This way we can get immediate feedback on how our people are doing.

Table 6 shows the impressive array of community-based services used by these PHCTs. Most frequently mentioned across all team types were local health units, Community Care Access Centres, diabetes services and the Children’s Aid Society. Participants from FHG/FHNs mentioned referring out for physiotherapy and associated therapies, mental health services, and breast screening services. Lack of referral to community services by the FPTUs in this study may reflect the presence of professionals such as physiotherapy or social workers at these teaching centres. CHC participants described referring to a wider range of community-based services than the other two team types and this may reflect the more community-based mandate of CHCs.
In summary, participants across all three types of teams described a wide range of prevention and health promotion activities as well as referral to multiple community-based services. The structure and funding of CHCs allows them to implement more health promotion initiatives and programs focused on communities. The findings from this study recommend the continuance of such funding for CHCs and to expand these opportunities to FGH/FHNs and FPTUs in order to enhance their prevention and health promotion strategies.
<table>
<thead>
<tr>
<th>Prevention and Health Promotion Activity</th>
<th>Teams</th>
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<tr>
<td></td>
<td>FHGs - 7</td>
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<tr>
<td><strong>Immunization</strong></td>
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<td>5</td>
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<td><strong>Smoking Cessation</strong></td>
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<tr>
<td><strong>Preventive Screening (e.g. breast, paps)</strong></td>
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<tr>
<td><strong>Nursing Moms</strong></td>
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<td></td>
<td>5</td>
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<td><strong>Flu Clinics</strong></td>
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<tr>
<td><strong>Posters &amp; Pamphlets</strong></td>
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<td></td>
<td>5</td>
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<tr>
<td><strong>Patient Education (e.g. diabetes, cholesterol)</strong></td>
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<td></td>
<td>4</td>
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<tr>
<td><strong>Case by Case (individual basis)</strong></td>
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<td></td>
<td>4</td>
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<tr>
<td><strong>Weight Loss, Nutritional Counselling</strong></td>
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<td></td>
<td>3</td>
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<tr>
<td><strong>Community-Based Activities (e.g. coaching, sponsorship)</strong></td>
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<td>2</td>
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<tr>
<td><strong>Psychology, Counselling</strong></td>
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<td>2</td>
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<tr>
<td><strong>Other In-House Services</strong></td>
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<td><strong>TV, Video</strong></td>
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<td><strong>Drug Rep Talks</strong></td>
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<tr>
<td><strong>Menopause</strong></td>
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<tr>
<td><strong>Hand-Washing (e.g. SARS)</strong></td>
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</tbody>
</table>

*Please note the numbers presented in Tables 5 and 6 may not accurately reflect all the prevention and health promotion activities these teams are currently providing nor represent all the community services to whom they refer. This information was collected during a discussion with the participants and did not utilize a survey tool or checklist. Therefore, participants may have simply not offered a comprehensive list of all their activities.
### Table 6. Community Services Utilized by PHCTs*

<table>
<thead>
<tr>
<th>Community Services</th>
<th>FPGs - 7</th>
<th>FPTU - 4</th>
<th>CHCs - 5</th>
<th>Total - 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Unit</td>
<td>7</td>
<td>3</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Community Care Access Centre (CCAC)</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Diabetes Programs</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Children’s Aid</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>VON</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Breast Screening</td>
<td>4</td>
<td>2</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Cancer Clinic</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Day Programs (e.g. at hospitals)</td>
<td>2</td>
<td>-</td>
<td>3</td>
<td>5</td>
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<tr>
<td>Schools</td>
<td>-</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Alzheimer’s Society</td>
<td>1</td>
<td>-</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Prenatal Care</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
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<tr>
<td>Meals on Wheels</td>
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<td>-</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Heart &amp; Stroke Society</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
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<tr>
<td>Arthritis Association</td>
<td>-</td>
<td>1</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Mother-Risk</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Breast Feeding</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Physiotherapy, Message, Podiatry, OT</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3</td>
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<tr>
<td>Home Care</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>2</td>
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<tr>
<td>HIV</td>
<td>1</td>
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<td>2</td>
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<tr>
<td>Alcoholic Anonymous (AA)</td>
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<td>Optometry</td>
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<tr>
<td>YMCA, Fitness</td>
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<td>Audiology</td>
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<tr>
<td>Immigrant Services</td>
<td>-</td>
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<td>Churches</td>
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<td>Fibromyalgia Groups</td>
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<td>Parkinson’s Association</td>
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<td>Ontario Provincial Police (OPP)</td>
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<tr>
<td>Crohns/Colitis Society</td>
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<td>Salvation Army, Homeless Shelters</td>
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<tr>
<td>Libraries</td>
<td>-</td>
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<td>1</td>
<td>1</td>
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<tr>
<td>United Way</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Family Violence Services</td>
<td>-</td>
<td>-</td>
<td>1</td>
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</tbody>
</table>

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3.6 Summary

This rich and valuable data set collected from 121 participants from 16 PHCTs, reflecting three practice types (FHGs/FHNs; FPTUs and CHCs), has provided an indepth view of the current state of teamwork and teambuilding on primary healthcare teams.

Three overarching themes emerged from the analyses: 1) what makes a team work - the foundation and pillars of teamwork; 2) challenges faced by primary healthcare teams and; 3) potential solutions and recommendations to help create, build and sustain primary healthcare teams. Analysis of the interviews also provided a "snapshot" of the current prevention and health promotion strategies used by these teams and the community agencies and services most frequently accessed by the study teams.

Participants strongly endorsed a shared philosophy as the foundation of team work. This shared philosophy was two-pronged and included a common vision regarding the provision of patient care (i.e. continuity) as well as a fundamental belief in the value of interprofessional, collaborative team practice, which was reinforced with personalities that “fit together”. Built on this foundation of a shared philosophy were the pillars of trust, respect and communication. These were viewed by participants as the core building blocks of what makes a team work. Embedded within each pillar were specific characteristics. In the pillar of trust were characteristics of relationship building, caring and recognition of scope of practice. Characteristics of reciprocity, feeling valued and working well together reflected the pillar of respect. Within the pillar of communication were characteristics of openness and approachability. Once a solid foundation of a shared philosophy was in place, and the pillars of trust, respect and communication were established, indicators of a well functioning team became evident. Participants from all three types of teams described a
wealth of activities, experiences and strategies as indicators of a well functioning team including: job satisfaction; dedication to work; experiencing the team as a family; adaptability to change; environmental tone; strategies to manage stress and conflict; and patient-centred care.

Thus the study findings have revealed what makes a team work and indicators of when a team is working. These findings may serve as the bedrock for further research but also educational initiatives to assist future PHCTs in the process of creating, building and ultimately sustaining their teams. This will be paramount with the rapid growth of PHCTs in Ontario to ensure the success of this healthcare reform initiative.

The analyses of the data also revealed both internal and external challenges to teamwork. The four major internal challenges to interprofessional practice included: (1) team composition, roles, and scope of practice, (2) leadership, (3) accountability, and (4) barriers to conflict resolution.

The challenges presented with regard to team composition, roles and scope of practice may be addressed through strengthening the pillars of teamwork (trust, respect and communication) and as such attenuate these challenges.

Leadership remains a controversial issue as PHCT’s evolve. The findings provide direction regarding the role of leadership on PHCT’s and the impact of leadership styles on team functioning. The team’s leadership must attend to business practices and processes as these practices are “the glue that keeps everything together”. In particular, regularly scheduled team meetings that provide opportunities for staff and management to meaningfully dialogue are important team-enhancing opportunities. As well, creating clarity of roles through job descriptions and implementing appropriate team policies, are crucial
business processes that must exist for teams to function well. Staff performance review/evaluations, and the inclusion of staffing in hiring processes are also vital business practices that facilitate team functioning and maintenance. The primary healthcare teams described four leadership styles. They included: 1) approachable and accessible leaders, 2) autocratic leaders, 3) abusive leaders, and 4) abandoning and unavailable leaders. These styles directly influenced the well being of team members and thus the overall functioning of the primary healthcare team and service delivery.

Four broad dimensions of accountability were identified: accountability to patients; physician accountability; personal accountability and; external accountability. Each dimension presented specific challenges to teamwork. In order create, build and sustain PHCT in the future these challenges will need to be addressed and will require change not only on a team level but also within the broader healthcare system.

Barriers to conflict resolution could seriously impede team functioning. Heavy workloads and lack of time to communicate about conflict could impede resolution. Leadership and power issues hindered recognition of the impact of conflict on team members and contributed to a resistance and lack of motivation to resolve conflict. Finally, a concern for hurting fellow team members’ feelings could be a barrier to conflict resolution when professional rules need to be enforced or issues are not brought forward. Recognizing feelings of team as family or friends could assist teams in resolving conflict in a positive way that preserves the integrity of a team that works. Again reinforcing the foundation of teamwork and developing methods and means to build and sustain the pillars of teamwork can move teams forward in their capacity for conflict resolution.
The four major external challenges included: (1) health human resources, (2) unrealistic patient expectations, (3) resources and commodities (time, funding, physical work space), and (4) access and wait lists. Participants expressed deep concern about the paucity of available healthcare professionals to provide primary healthcare. In addition, they felt overwhelmed by the enormity of patient volumes and as such unable to satisfactorially meet patients needs. Related to this was the second external challenge – the unrealistic expectations of patients and lack of patient accountability. The third external challenge related to limited resources and commodities, specifically a lack of time, funding needs and inadequate physical work environments. Together these seriously impacted the capacity for optimal teamwork and healthcare delivery. The fourth external challenge was the frustration and stress experienced by PHCTs as they attempted to negotiate the long waiting lists in order to accommodate their patients needs and struggled to locate and access specialist care.

Key solutions offered by the participants addressed: (1) public education and patient accountability, (2) secure funding mechanisms (3) optimal physical work environments, and (4) methods and means to build and sustain teams specifically team development and team building strategies and mechanisms for communication. Most participants described their teams as proactive and prepared to engage in seeking solutions to both the internal and external challenges they face on a daily basis. As such the solutions they proposed attended to internal challenges (i.e. developing mechanisms to enhance communication, a fundamental pillar of teamwork) as well as external challenges (i.e. participating in activities to increase patient accountability).
Finally, with regard to prevention and health promotion the analysis of the data revealed a variety of initiatives offered by these teams and the numerous community-based services they utilized.

In summary, what makes a team work is a complex and dynamic interplay of multiple dimensions and reinforcing characteristics. As PHCT teams move towards interprofessional collaborative practice the foundation and pillars of teamwork are paramount in facilitating successful teamwork. The indicators, as identified in this study, of when a team works well together can serve as important variables in the development of evaluation measures to assess interprofessional collaborative teamwork. The internal and external challenges facing PHCTs can be meet by developing creative and innovative solutions. The primary health care climate is ready for change and PHCTs need not be daunted by the challenges before them but rather inspired with various ways to create, build and sustain teams.
APPENDIX 1 – SEMI-STRUCTURED INTERVIEW GUIDE

PURPOSE: To explore and understand the issues and challenges to teamwork and teambuilding within Primary Health Care Teams.

BASIC DEMOGRAPHIC ITEMS:
1) What is your gender?
2) What is your age?
3) What is your occupation?
4) What year did you graduate?
5) How many years have you worked in your current position?

A) TEAM DESCRIPTION:

1) How would you describe your team?
   Probe: Who are the members of your team?
   How often do they meet?

2) How do you communicate amongst your team members re: administrative issues, patient care, etc.
   Probe:
   • Formal vs. informal communication
   • What is the frequency of contact/team meetings?
   • Do you discuss your communication skills?

3) What makes your team work?
   Probe:
   • How did this happen?

4) How do you sustain your team?
   Probe:
   • What kind of activities do you do that foster team development?
   • What professional development activities does the team participate in?

5) How do you attend to shifts and changes on the team?
   Probe:
   • How does the team integrate new staff?
   • Acknowledge retirements?

6) How are new ideas introduced to the team?
   Probe:
   • How responsive is the team to new ideas?
B) TEAM ROLES:

1) Who assumes what roles on the team?
   Probe:
   • How do those roles get decided? (How do you decide who is going to do
     what?)
   • Who decides on these roles?
   • Is there a formal decision-making process?

2) Do roles change and how does this happen?

3) How did you learn about each others roles? Skills? Knowledge base?

C) POWER STRUCTURES:

1) Who is in charge?
   Probe:
   • Does that change?
   • How?

2) Who is accountable?
   Probe:
   • Is accountability shared?
   • What are the barriers to shared accountability?

D) CONFLICT:

1) How does your team deal with differences?
   Probe:
   • Can you give an example?

2) Can you identify barriers to team conflict resolution?

3) Can you identify facilitators of conflict resolution?

4) How do you know when your team is working? Not working?

5) How does the team deal with stress?

E) HEALTH PROMOTION AND PREVENTION

1) What activities does your team participate in to assist in health promotion and
   prevention initiatives?
   Probe:
   • Response to CPG’s (Clinical Practice Guidelines)

2) How do these health promotion and prevention strategies get initiated?
   Probe:
   • What team member initiates them?
   • Who assumes what role in this activity?
3) What community services does your team use to facilitate health promotion and prevention efforts?

F) TEAMBUILDING:

1) What would help you in teambuilding?
2) What would help sustain your team?
3) What do you identify as necessary features of collaborative practice?
4) What does successful collaborative team practice require?
5) What are some of the within team challenges that interdisciplinary health care teams face as they come together in collaborative practice?
6) What do you believe are some of the external factors that challenge primary health care teamwork?
REPORT III:

PRIMARY HEALTH CARE PATIENT ACCESS ENVIRONMENTAL SCAN AND SECONDARY ANALYSES OF THE CANADIAN COMMUNITY HEALTH SURVEY (CCHS 2.1)
REPORT III

PRIMARY HEALTH CARE PATIENT ACCESS ENVIRONMENTAL SCAN AND SECONDARY ANALYSES OF THE CANADIAN COMMUNITY HEALTH SURVEY (CCHS 2.1)

Final Report for Actively Building Capacity in Primary Health Care Research (ABC Project)

The Ministry of Health and Long-Term Care

Primary Health Care Transition Fund

A Partnership of the

Centre for Studies in Family Medicine of The University of Western Ontario

and the

Ontario College of Family Physicians

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OVERVIEW

This report covers two of the five deliverables of The University of Western Ontario’s components of the Actively Building Capacity (ABC) Project for the Primary Health Care Transition Fund. These deliverables were:

1. Review patient access surveys in an environmental scan
2. Conduct surveys to fill in gaps in access databases

The first part of this report describes the findings of the environmental scan of the review of patient access surveys and databases. The second part reports on the secondary analysis of the Canadian Community Health Survey (CCHS) [2.1] 2003 data to glean profiles of the population with and without access to primary health care.

1. INTRODUCTION

The Ontario College of Family Physicians response to the George Panel on Health Professional Human Resources Report recommended that surveying to obtain “the number of patients per community with a broad spectrum family doctor [was] a key access measurement in family medicine” (Kasperski et al., 2001, pp. 6-7). The OCFP also noted that physician or population data driven models of health human resource and patient access issues may be inadequate, since simple head counts did not adequately capture the range and type of services that could be provided to give patients a full-spectrum of cost-effective primary health care services.

The definition of primary health care had received intense consideration of late as federal, provincial and territorial governments attempt to restructure health care services to
be more responsive, equitable and cost-effective within the Canadian publicly funded, single payer framework. Within the context of the family health teams program, the Ontario Ministry of Health and Long Term Care (MOHLTC) had defined the primary health care provider as the “‘navigator’ of the health care system, providing clinical services as close to home as possible, system access and continuity of care” (Family Health Teams: Advancing Primary Health Care Fact Sheet, 2005, MOHLTC, p. 1). The National Primary Health Care Awareness Strategy recently released a consensus definition of primary health care developed through consultation with federal, provincial and territorial health partners. As expressed in their September 20th, 2005 Fact Sheet, their definition included four key health care elements that include teams, access, information and healthy living. Their description of primary health care was multifaceted. The challenge for primary health care researchers is to operationalize this definition into variables that are available from currently existing data sources.

The University of Western Ontario (UWO) component of the Actively Building Capacity Project in Primary Health Care Research (ABC Project) has reviewed and collated the existing patient access databases. The purpose of this report is to describe our findings from the environmental scan examining existing databases for information on patient access to primary health care. The second part reports on the secondary analysis of the Canadian Community Health Survey (CCHS) [2.1] 2003 data to glean profiles of the population with and without access to primary health care. Additionally we will attempt to make recommendations on the types of indicators that should be surveyed from Ontario residents to remediate the gaps in the current data collection processes. Developing more
reliable and pertinent databases will ensure more timely and valid information is available to inform primary health care patient access policy decisions.

2. PART I: PATIENT ACCESS ENVIRONMENTAL SCAN

2.1 Methods

Environmental scans can be an unobtrusive and cost-effective means for policy-makers and researchers to learn what is known and not known by examining the external environment of a given problem (Hatch and Pearson, 2005; Marton, 2001; Weiss et al., 2002). The purpose of the environmental scan was to systematically find and interpret relevant published reports and available data sets on a given topic. Environmental scans employ flexible methodologies and are traditionally intended for government reports that prioritized timeliness over rigour (Marton, 2001).

Materials examined for this environmental scan were focused on governmental, non-governmental sources and a literature search. We have listed sources used in Appendix One. Scan techniques from Internet searches, conversations with population health researchers and database experts, were used to identify relevant sources of information. Sources deemed relevant included:

- Non-governmental data sources (i.e., Canadian Health Information Institute);
- National Surveys (i.e., Statistics Canada) for both databases and data dictionaries;
- Provincial Government health data sources (ICES); and,
- Examination of academic literature and policy documents.
2.2 Results

Two research agencies are in the process of developing primary health care indicators; the Institute for Clinical Evaluative Sciences, and the Canadian Institute of Health Information (Webster 2005).

2.2.1 Institute for Clinical Evaluative Sciences and Information Available through Provincial Billing Data Sources

The information and reports available from ICES were potentially the most useable sources of data for understanding the how patients accessed primary health care. ICES has a mandate to analyze provincially collected data bases such as the Ontario Health Insurance Plan, the Ontario Drug Benefit Plan and hospital discharge data. Provincial databases tended to focus on data collected from billing and service usage data sets (i.e., outpatient services, drug benefit dispensing, nursing home care indicators). Identifying billing codes that were specific to primary health care services (e.g., childhood immunizations) may be a useful way to determine the primary care services of those professions eligible to have OHIP billing numbers, but do not inform us of the services provided by other practitioners who do not. However, because of the sensitive nature of these data, there were limitations because of restricted access, privacy and ownership of data. Currently, there are several projects under development that are examining primary health care issues and these included:

1) Global indicators of system functioning:
   a) Administrative data indicators for quality of care testing
   b) Atlas reports: primary care services in Ontario
   c) Continuity of care and quality of primary care services
d) Interdisciplinary primary health care (London). Part I: Health administrative data analysis
e) The Ontario printed educational message (OPEM) trial

2) Targeted indicators of at-risk/vulnerable populations

a) Evaluation of primary health care payment and delivery models on the screening, detection and control of hypertension  
b) Life threatening trauma and prior doctor visits  
c) Proportion of Ontario seniors who have high pharmacy and high family physician continuity of care  
d) Quality of primary care received by young children in Ontario and health outcomes  
e) Rural surgery access project

Also, were a number of published studies that examined facets of primary health care and included analyses on administrative databases with at-risk populations including First Nations persons residing on reserves (Shah et al., 2003); diabetes care (Shah et al., 2005), mental health patients (Steele et al., 2004), cardiac care with other co-morbid conditions (Austin et al., 2005), joint replacement (Coyte, 2000), and urban populations (Glazier et al., 2005).

2.2.2 Health Indicators from the Canadian Institute of Health Information

Health indicators were an amalgamation of all the current health administrative databases in Canada. Theses databases included:

- The National Public Health Survey (1998);
- The Canadian Community Health Survey (2001 to current);
- The National Longitudinal Survey of children and Youth
- Provincial hospital admission data;
- Provincial health insurance data;
- Provincial drug benefit data;
- Nursing home admissions data;
- Vital statistics data for birth, death, stillbirth etc.;
- Canadian Cancer Registry;
Many of the limitations of these derived statistics for primary health care were outlined in the Health Indicators Definitions and Data sources (2004). For example, asthma readmission rate was defined as the number of unplanned readmission to hospital after discharge for asthma. These rates were adjusted for age, sex and co-morbidities. The purpose of calculating these asthma hospital re-admission rates was to advise health regions as to the appropriateness of their hospital treatment and the relationship between hospitals and their community practitioners. However, as the CIHI definition concludes, “these rates should be interpreted with caution due to potential differences in the coding of co-morbid conditions across provinces and territories” (Health Indicators Definitions and Data Sources, 2004, p. 31). Also, this indicator seemed to speak to hospital discharge policies and only indirectly spoke to primary health care patient access.

More relevant health indicators of primary health care were mammography screening for women aged 50 to 69, PAP smear screening for women aged 18 to 69, and influenza vaccination for ages 65 or older. These indicators were considered to be markers of accessibility to care in health care system performance. However, these indicators may give a limited picture of primary health care access. Two of the three indicators targeted women and two of these indicators target persons older than 50 years: as a result, children and adolescents and men between the ages of 18 to 65 had no representation in these
indicators. Additionally, PAP smears often happen in a family physician’s office but may also happen in a community clinic or at a gynecologist’s office. Mammography typically happens in a community clinic or a hospital radiology department and patients, after their first referral, may contact the clinic directly for their appointments.

Also, some of indicators may not have widespread public acceptance and the percentage of persons receiving the service may indicated the degree of acceptance of the service and not its accessibility. For example, public policies encouraging universal flu shot coverage began in Ontario in 2000. According to OMHOLTC reports, the actual rates of coverage for the year 2000-01 cycle were 44% of the population 16 years and older. However, the breakdown of these coverage rates show that young children under the age 4 years have immunization rates of 20% and children aged 5 to 18 years have coverage rates to 30%. The highest rates of coverage were for persons over the age 65 years with a coverage rate of 79%. While this type of targeted coverage was appropriate given the lethality of influenza, it does not provide an adequate picture of the accessibility to primary health care in Ontario. CIHI will have developed relevant primary health care indicators by March 2006; it will still take additional time to implement the data collection and dissemination phases of these projects (Webster, 2005).

2.2.3 Canadian Community Health Survey

The Canadian Community Health Survey was a cross-sectional telephone survey administered by Statistics Canada to Canadian respondents. Its predecessor was the National Population Health Survey. The first cycle was put in the field in 2000 (CCHS 1.1) and focused on general health; the following year another survey was fielded and focused on mental health (CCHS 1.2 2001). The second general health cycle was fielded
in 2003 and (CCHS 2.1 2003) was given for public release in May 2005. Survey 2.1 was extensively revised from 1.1 and has many variables relevant to primary health care.

There may be many reasons that a patient does not access a health care and these reasons may only be partially related to the accessibility of these services. For example, many women have been advised by their physicians to have a PAP smear or mammography but the women do not want the services for personal reasons. The Canadian Community Health Survey does ask their respondents to comment on why they did not receive care for these services and list reasons such: not available in the patient’s geographic area or when needed, or in a timely manner, or felt the services would be inadequate. Other personal discretionary factors listed included that the patient was too busy, they didn’t get around to it, didn’t know where to go, had transportation problems, language or personal/family problems, they dislike or where afraid of doctors, or decided not to seek care.

Factors examined by the CCHS that may be relevant to primary health care include blood pressure monitoring, breast examination, physical check-ups, colorectal cancer screening, influenza vaccination, mammography, maternal experiences, PAP Smear tests, prostate specific antigen (PSA) testing, and consultation with mental health professionals. Additionally, respondents were asked if they had a regular medical doctor. If they did not have a regular medical doctor, were asked to describe their attempts to locate one (i.e., has no access to regular physician despite making efforts to try to find one or does not have a regular physician and has not tried to find one). This variable may be used to determine whether access to a physician differentiates levels of care, attitudes towards health care, and potential gaps in service.
The Canadian Community Health Surveys had many of the variables that may answer some of these questions now. However, this data will need to be re-analyzed with the intention of specifically focusing on primary health care patient access. The ABC Project at the University of Western Ontario conducted a secondary analyses of the Canadian Community Health Survey (CCHS) [2.1] 2003 data to glean profiles of the population with and without access to care. These secondary analyses met two purposes: to identify what is known about Ontarians access to primary health care; and to indicate how the CCHS may be revised to collect more relevant primary health care patient access data.

3. PART II: SECONDARY ANALYSES OF THE CANADIAN COMMUNITY HEALTH SURVEY 2.1

3.1 Methods

3.1.1 Data Analysis

In this analysis, logistic regression was used to determine the predictors of access to primary health care among respondents to the CCHS [2.1] 2003 survey ages 12 and over who resided in the province of Ontario. 1 By using logistic regression, results provided substantive information surrounding a number of health indicators and their probability of predicting access outcomes. The direct logistic regression procedure was utilized because the goal of the analysis was to determine the predictors of access to a regular medical

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1 This analysis is based on Statistics Canada’s Canadian Community Health Survey 2.1., Public Use Microdata file, which contains anonymized data collected in the year 2000/2001. All computations on these microdata were prepared by the Centre for Studies in Family Medicine and the responsibility for the use and interpretation of these data is entirely that of the author(s).
doctor and whether or not survey respondents had tried to gain access to primary health
care services rather than to determine the importance of predictors.

The logistic regression procedure predicted the dependent variable on the basis of
independent health indicators to determine the percent of variance in the dependent
variable explained by the independents. Using a maximum likelihood estimation procedure
the dependent variable is the logit variable or the natural log of the odds of the dependent
variable occurring or not occurring. Therefore, the logistic regression procedure provides
an estimate of the probability of the access dependent variable of interest occurring based
on the health indicators used in the analysis. The procedure was completed using SPSS
version 12.

3.1.2 Sample

The following analysis was conducted using the Ontario portion of the Canadian
Community Health Survey [2.1] 2003: public use microdata file produced by Statistics
Canada and Health Canada (CCHS) Cycle 2.1 (2003). The goal of the (CCHS) Cycle 2.1
(2003) survey was to provide detailed information on the health of both the Canadian
health system and individual Canadians aged 12 and over. In addition, (CCHS) Cycle 2.1
(2003) was also focused on collecting data at the provincial levels. (CCHS) Cycle 2.1
(2003) collected data from individuals age 12 and over who were living in private
dwellings across all ten provinces and three territories. Persons who lived on both Indian
Reserves and Crown lands, residents of institutions and those full-time members of the
Canadian Forces along with people in remote areas of Canada were not included in the
(CCHS) Cycle 2.1 (2003) survey. Overall, the survey represented nearly 98% of the
Canadian population. The survey used three specific sampling frames to select the final
sample of households (n=103,700). For the purpose of this analysis, data for the logistic regression analysis were a sub-set of the (CCHS) Cycle 2.1 (2003) survey representing respondents from Ontario (n=42,754) (Statistics Canada, 2005).

### 3.1.3 Outcome Variables

#### 3.1.3.1 Model 1: Access to Regular Medical Doctor

The dependent variable for model one in this analysis is regular medical doctor of Ontario respondents aged 12 and over. To capture the target population all Ontario cases were selected from the full dataset. The dependent variable ‘access to a regular medical doctor’ [n=42,754] contains the following responses and frequencies: 1-yes representing individuals who have access to a regular medical doctor (91.9%), 2-no indicating individuals who do not have access to a regular medical doctor (8.1%). Missing cases for this analysis represented <1% of the total respondents.

#### 3.1.3.2 Model 2: No Access to Regular Medical Doctor-Tried versus Not Tried to Gain Access

The dependent variable for model two in this analysis is ‘No Access to a regular medical doctor: Tried versus Not Tried to gain access’ (n=3,498) among those who indicated they did not have access to a regular medical doctor from the anchoring survey question. This variable was a derived variable created specifically for the purpose of the logistic regression analysis. The ‘no access to a regular medical doctor: ‘Tried versus Not Tried to gain access’ contains the following responses and frequencies: 1-no access-tried representing individuals who have no access to a regular medical doctor and have tried to
gain access (59.4%), 2-no access-have not tried representing individuals who do not have access to a regular medical doctor and have not tried to gain access (40.6%).

### 3.1.4 Predictor Variables

The predictors for this analysis were organized according to the Canadian Institute for Health Information (CIHI) ‘Health Indicator Framework’ [See Appendix 2 for a detailed listing of the theoretical framework]. CIHI has developed information and health indicators designed to measure both the health of Canadians and the Canadian health care system. In general, the framework is divided into 4 distinct dimensions: Health Status, Non-Medical Determinants of Health, Health System Performance and Community and Health System Characteristics (Canadian Institute for Health Information, 2006). For the purpose of this analysis the first three dimensions were used to select predictors to be included in two logistic regression models. Within each dimension, a number of measures were used to capture each dimensions characteristics. Both logistic regression models used identical predictors, thus the difference between models in this analysis is the outcome of interest.
Table 1: Logistic Regression Analysis [Model 1 and 2] Predictor Variables

CCHS 2.1 [2003]

**HEALTH STATUS**

**Health Conditions**
Standard Weight [International Standard]

**Morbid Conditions**
Do you have high blood pressure
Do you have emphysema
Do you have diabetes
Do you have heart disease
Do you have cancer
Do you have a mood disorder
Do you have an anxiety disorder

**Well-Being**
Derived: Self-Rated Health
Derived: Self-Rated Mental Health

**NON-MEDICAL DETERMINANTS OF HEALTH**

**Health Behaviours**
Type of Smoker
Type of Drinker
Physical Activity Level

**Living/Working Conditions**
Highest Level of Education
Income Adequacy
Marital Status

**Personal Resources**
Self-Perceived Life Satisfaction

**HEALTH PERFORMANCE**

**Acceptability**
Rating of availability of health care in community
Rating of quality of health care in community

**DEMOGRAPHIC VARIABLES**

Sex
Age
3.1.5 Health Utilization Variables

For individuals without access to a regular medical doctor, who also indicated they had tried to gain access (n=2,068), a descriptive analysis was specifically done to focus on their health care utilization information. Within the past 12 months at the time of the survey, 49% stated they had not seen a family or general practitioner whereas 51% stated they had been seen by a family or general practitioner within the previous 12 months. Therefore, approximately half of the people without access to a regular medical doctor had seen a family or general practitioner. Among the same group, 11% indicated they had consulted with a nurse and less than one percent indicated they had been seen within the past 12 months by a social worker or counsellor.

3.2 Results of the Secondary Analysis of CCHS 2003

The individuals who had access to a regular medical doctor in Ontario are shown in Figure 1. We see that the vast majority of the 42,754 people surveyed reported that they had access. We also see that of the 3,498 who did not have access 1,413 had not tried to contact a regular medical doctor whereas the remainder had tried. Therefore, 91.9% had a regular family doctor and 8.1% did not. When those with no regular MD were compared to those who had a regular MD, people who were more likely to lack access to a regular MD were: poor mental health versus those with excellent; those who are inactive versus those who are active; those with low income adequacy versus those who had mid to high income adequacy; those who were not married versus those who were married; and those who perceived poor availability of services versus those who perceived excellent availability of services. Table 1 shows that these statistically significant odds ratios ranged
from 1.2 to 2.5. Table 2 shows the characteristics of people who were less likely to lack access to a regular MD. Here we see that the characteristics are: people with morbidity compared to those with no morbidity; people with high school education versus those with post-secondary education; people who perceived a fair quality of care versus those who perceived their quality of care to be excellent; and women versus men. On Table 2 we see those odds ratios ranging from .1 to .7.

Of those of the population found to lack a regular medical doctor (i.e. those we have labelled to lack access) 59.4% had tried to gain access, 40.6% had not tried to gain access. The characteristics of those who lacked access and had tried to gain access were as follows: more likely to have fair self-rated health versus excellent self-rated health; be former drinkers versus had never drank; have a poor rating of availability versus an excellent rating of availability; have morbidity for example, high blood pressure versus no morbidity; and be women versus men. See Table 3. Individuals who were less likely to have tried to gain access were: underweight compared to those of normal weight; inactive compared to those who are active; and single compared to being married.

3.3 Discussion

Two of the key findings were that 91.9% of Ontarians have access to regular medical care and that half of those without access tried and failed to find a regular medical doctor (i.e. 4.8%).

In terms of implications of these findings some of the characteristics of the people who lack access to regular medical care raise concerns about the equity of access. For example, one may be concerned that people with the following characteristics lack access: people with poor mental health; people who are inactive; people who are not married;
people who are men; and people who perceive they have low income adequacy. This therefore is a profile of those who lack access to regular medical care in Ontario.

Of the people who have no access, some have tried to gain access. We could consider these to be people who have explicit and expressed perceived need for care. The characteristics of these are: that they have fair health; that they are former drinkers; that they have high blood pressure; and that they are women. People who are less likely to have tried to gain access might be considered as representing unexpressed needs or unrecognized needs. The people who fit this profile are underweight, inactive, and single.

### 3.4 Summary and Conclusions

The Canadian Community Health Survey (CCHS) has therefore provided a profile of the prevalence and characteristics of people who lack access to a regular MD in Ontario and the prevalence and the characteristics of those who lack access and who have tried to gain access.

While the CCHS has provided these important data, we noted that the CCHS could not provide data specific to primary medical care or indeed primary health care. This is a recommendation for future research infrastructure, i.e. to provide data on Ontarians who have access or lack access specifically to primary medical care and primary health care.

Further, the Canadian Community Health Survey could not provide universal information on what services had been utilized by the people who had access or did not have access to a regular medical doctor, or indeed those who did not have access and tried or not tried to gain access. It is important in the future to have a profile of the kind of
services that are utilized by people who do not perceive they have access to regular medical care.

In conclusion then, we recommend future research infrastructure which will provide information on access to primary medical care, primary health care and when people lack access, to provide universal information on what kind of services medical and allied health professionals are accessed by that population.
Figure 1: Numbers of Ontarians with and without Access based on CCHS 2003 Data

Table 2: Characteristics of persons who lack access to a regular MD – CCHS survey data

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>ODDS RATIOS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor mental health versus excellent</td>
<td>2.0</td>
</tr>
<tr>
<td>Inactive versus active</td>
<td>1.2</td>
</tr>
<tr>
<td>Low income adequacy versus mid/high</td>
<td>1.5</td>
</tr>
<tr>
<td>Not married versus married</td>
<td>2.0</td>
</tr>
<tr>
<td>Poor availability versus excellent</td>
<td>2.5</td>
</tr>
</tbody>
</table>

*statistically significant, based on Logistic Regression.
e.g. those persons with poor self-reported mental health had two times the chance of lacking access compared to persons with excellent self-reported mental health.
Table 3: Additional characteristics of persons who lack access to a regular MD – CCHS survey data

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>ODDS RATIOS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbidity vs no morbidity</td>
<td>0.6</td>
</tr>
<tr>
<td>HS versus post sec</td>
<td>0.7</td>
</tr>
<tr>
<td>Quality of care fair versus excellent</td>
<td>0.1</td>
</tr>
<tr>
<td>Women versus men</td>
<td>0.4</td>
</tr>
</tbody>
</table>

*statistically significant, based on Logistic Regression.
e.g. those persons who reported morbidity were less likely to lack access than persons who reported no morbidity.

Table 4: Characteristics of persons who lacked access and had tried to gain access compared to those who had not tried – CCHS survey

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>ODDS RATIOS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair self-rated health versus excellent</td>
<td>3.0</td>
</tr>
<tr>
<td>Former drinkers versus those who never drank</td>
<td>1.7</td>
</tr>
<tr>
<td>Poor rating of availability versus excellent</td>
<td>7.0</td>
</tr>
<tr>
<td>Morbidity (HBP) versus no morbidity</td>
<td>2.3</td>
</tr>
<tr>
<td>Women versus men</td>
<td>2.0</td>
</tr>
</tbody>
</table>

*statistically significant, based on Logistic Regression.
e.g. those persons with fair self-rated health were three times as likely to have tried to gain access than those who reported excellent health.
REFERENCES


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APPENDIX 1: NATIONAL/LOCAL SURVEYS


Canadian Institute for Health Information (CIHI). CIHI Health Indicator Check List for Health Indicators (2004) URL>>http://www.cihi.ca/hirpt.jsp/HIDispatcher.jsp


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APPENDIX 2: THEORETICAL FRAMEWORK

CANADIAN INSTITUTE FOR HEALTH INFORMATION:

HEALTH INDICATORS

Health Indicator Framework

HEALTH STATUS
(How healthy are Canadians?)
Health status can be measured in a variety of ways, including severity, health conditions, mortality or outcomes.

- Well-Being
- Health Conditions
- Human Function
- Deaths

NON-MEDICAL DETERMINANTS OF HEALTH
(What factors affect our health?)
Non-medical determinants of health are factors that influence our health and, in some cases, access to health care.

- Health Behaviours
- Living and Working Conditions
- Personal Resources
- Environmental Factors

HEALTH SYSTEM PERFORMANCE
(How healthy is the health care system?)
These measures evaluate various aspects of the quality of health care.

- Acceptability
- Accessibility
- Appropriateness
- Competence
- Continuity
- Effectiveness
- Efficiency
- Safety

COMMUNITY AND HEALTH SYSTEM CHARACTERISTICS
(What is the community like?)
These measures provide useful contextual information, but are not direct measures of health status or the quality of health care.

- Community
- Health System
- Resources