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1. **INTRODUCTION**

The *Health Professions Act* (HPA) mandates the College of Physicians & Surgeons of Alberta (CPSA) to regularly review physician practice as part of their Continuing Competence Program. To date, the main tool for this task is the Physician Achievement Review (PAR) Program.

The purpose of the PAR Program is to assist regulated member-physicians to recognize deficiencies and improve where necessary aspects of their practice. Members are required to participate in a general assessment under the PAR Program every five years. While research suggests the PAR Program does help to reveal and identify some aspects of quality practice, recently the CPSA has received feedback from members that a different process may be of more value and relevance.

CPSA Council has given direction to conduct a pilot project with regard to the HPA-mandated periodic assessment of physicians. Although it is planned to modify the review process for the entire profession, Council directed that initially family practice physicians and clinics should be examined.

Focusing on promoting excellence and adhering to the Competence Committee’s Design Principles, the primary aim of this pilot project and subsequent program redesign is not to weed out those physicians who are not meeting general competencies and Standards of Practice; but rather to provide meaningful feedback that will inspire physicians to reflect and embrace new ideas and resources to help meet Standards of Practice and provide excellent medical practice to their patients.

2. **METHODS**

A mixed-methods approach was implemented in data collection. Two unique surveys, eight focus groups and multiple stakeholder consultations were employed as varied sources from which to collect data.

The first survey, “Survey #1” was sent to the entire profession (~ 9,000 physicians in Alberta) in July 2015. Goals of Survey #1 were to: Engage the profession in redesigning and improving the existing PAR process; alert the profession that change is occurring; test out some key concepts of physician Quality Improvement (QI); and identify interested and/or enthusiastic physicians to help develop this further. Basic demographic data of participants was also collected. SPSS v.23 was used to generate a multivariate general linear model for data analysis, performed by a member of the research team with expertise in epidemiological practices and quantitative research methodologies.

A second survey, “Survey #2” was sent to 402 physicians who had self-identified in Survey #1 that they would be willing to participate in further project research. Specifically, the goals of Survey #2 were to seek feedback on a preliminary list of quality indicators presented by the CPSA, and to obtain suggestions on additional indicators of quality. Participants were asked to rate various quality indicators on a scale of 1-6, where 1 = Very Poor, 2 = Poor, 3 = Fair, 4 = Good, 5 = Very Good, and 6 = Not Applicable. Basic demographic data of participants was also collected.

Focus groups were held from October - December 2015 with physicians across Alberta: two groups in Edmonton, two in Calgary, and one focus group each in Red Deer, Lethbridge, Medicine Hat and
Grande Prairie. Groups were two hours in length and took place in a private room at a local restaurant.

Stakeholder consultations to seek input and raise awareness to the CPSA pilot were held across the province in the latter half of 2015 and continue into 2016.

Themes and conclusions based on the focus group discussions and stakeholder consultations, triangulated with the results from Survey #1 and Survey #2 will be presented to the PDT in January 2016 for feedback and suggestions. Following this, a 1-page executive summary version of this research report will be presented to all participants, in addition to Council and membership and any other applicable knowledge-users. It is anticipated that the research will be synthesized by March 2016, and the executive summary and full research report will be completed in April 2016.

3. COMMUNICATION

To alert and engage the profession in the College’s general practice review improvement process, we set the following 2015 communications target outcomes:

- Response rate to our member survey of more than 15 per cent.
- More than 50 member volunteers for future stages of the process.
- More than 75 per cent of respondents surveyed in the discovery stage support the College making improvements to our general practice review process.

Our initial survey response rate (25%) was a record response by our members for the College, and exceeded our 15% response rate target by 10%. Our call for volunteers resulted in 402 self-identified ambassadors for future stages of the process, far exceeding our target of 50 volunteers. Feedback was exceptionally positive. Members consistently gave highest marks for being heard and supporting improvement. In fact, we have not identified any opposition in our discovery process to the College proceeding with this improvement, exceeding our third communications target of reaching at least 75% support for this change through the process.

4. RESULTS

4.1 Survey #1

Survey #1 was sent to all practicing registered physicians in Alberta (9,021 total). 2,215 responded to the survey, which correlates to a 25% response rate. Statistically there is a 99% probability that these results are within 2.4% of true value. There does not appear to be major significant differences in terms of the demographics of the sample versus the CPSA register in terms of age/longevity of practice, gender, family practice vs. specialist or Canadian-trained MD vs. foreign-trained MD. Mean scores for current PAR Program (on scale of 1-10, where 1 = not at all successful and 10 = extremely successful), were all around 5 indicating that most physicians do not think PAR is successful in assessing the dimensions listed (medical knowledge, clinical skills, communication skills, practice administration, patient management, adherence to SOP’s, professionalism, team functioning, easy to participate, inspires reflection in practice, motivates clinical practice improvements,
provides a learning opportunity). Results from multivariate statistical analysis controlling for possible confounders showed that:

- Female physicians rated “inspires reflection” and “motivates clinical practice improvement” significantly lower than males
- Specialists rated “easy to participate” significantly lower than family physicians
- Physicians in solo practice rated “group/team measures”, “both individual and group measures” and “local/system/provincial type measures” significantly lower than non-solo practice physicians
- Canadian trained MDs rated “group/team measures”, “both individual and group measures” and “local/system/provincial type measures” significantly lower than non-Canadian trained MDs
- Physicians in solo practice rated “written feedback to groups”, “written feedback to both individuals and groups”, “in-person feedback to groups” and “in-person feedback to individuals and groups” significantly lower than non-solo practice physicians
- Canadian trained physicians rated every category significantly lower than non-Canadian trained physicians

There were 303 text responses related to PAR which were substantially negative. These responses were grouped into 8 key themes: Irrelevant; Subjective/biased; Easy to cheat; Discriminatory; Confusing; Time-consuming; Repetitive; and Waste of money.

Overall, respondents valued individual feedback from the College (over group/team feedback; both individual and group feedback; and local/system/provincial-type feedback), and also ranked individual feedback as “most important” type of feedback.

The current review program (PAR) clearly needs some work. Canadian physicians particularly disliked PAR. Individual measures for feedback and assessment are preferred. Multisource feedback, standards of practice and continuous professional development measures are preferred. Individual written feedback (possibly in-person) is preferred over group feedback.

4.2 Survey #2 – Quality Indicators

In September 2015, Survey #2 was sent to the 402 volunteers and shared with stakeholders to assess the kinds of quality indicators and practice characteristics physicians believe the CPSA should consider when assessing physician practice. A total of 166 physicians responded, correlating to a response rate of 41%, and 116 respondents completed the Survey #2 in full. Attributes are listed from the top as “most indicative of quality” to least. Percentage indicates the percent of respondents that considered each quality indicator to be a “good” or “very good” quality indicator.

1) Documented and accessible current medication list = 88.7%
2) Documented and accessible problem list = 85.3%
3) Documented periodic review = 83.4%
4) Medication review process for high risk patients = 82.4%
5) Proactive panel management (if applicable) = 81.3%
6) Quality of charting = 79.8%
7) Infection prevention and control policies and adherence to those = 78.8%
8) Measurement of continuity of care (if applicable) = 78.8%
9) Access to Netcare = 78.4%
10) Office/clinic appearance = 75.4%
11) Process for consultation management and reconciliation of outstanding referrals = 75.4%
12) Process for handover and cross coverage = 74.4%
13) Identification of & communication w/ patient’s primary care provider in episodic clinic settings = 73.2%
14) Process for and quality of after-hour care management = 72.9%
15) Presence of care plans where appropriate = 72%
16) Regular team meetings for discussion of process and quality issues = 70.8%
17) Participation in any quality initiatives such as HQCA Access Improvement Measures (AIM) = 67.8%
18) Use of an EMR for documentation of visits, prescriptions and requisitions = 67.5%
19) Choosing Wisely Initiative® = 67.3%
20) Access to Pharmacy Information Network (PIN): = 67.3%
21) Ability to define an attached patient panel (if applicable) = 67.2% yes
22) Consideration for contingency plans for those patients whose needs cannot be met = 66.7%
23) Lab and DI data utilization compared to peers = 66.4%
24) Existence of a relevant Continuous Professional Development Plan: Go to Rules = 65.7%
25) Ability to produce health context profiles such as Cumulative Patient Profile = 65.2%
26) Group team function (e.g. internal, Primary Care Network) = 65%
27) Prescribing data - narcotics and benzodiazepines = 64.2% yes
28) Existence of a current Privacy Agreement = 64.1%
29) Measurement of access to appointments (e.g. third next available) = 63.7%
30) Use of EMR to generate reports and measurements = 63%
31) Referral data compared to peers = 61.8%
32) Identification of a clinic medical director who coordinates clinic function and policies = 61.1%
33) Ability to generate patient panel reports and measures = 59.5%
34) Prescribing data – antibiotics = 58.5% yes
35) Use of an EMR for scheduling = 58.2%
36) Average number of patients seen per day compared to peers = 57.7%
37) Membership in a Primary Care Network: Primary Care Network = 55.4%
38) Existence of an office policy manual (job descriptions and clinic processes) = 54.6%
39) Emergency room utilization by a patient panel compared to peers = 53.6%
40) Awareness of measurement tools for determining an appropriate patient panel size = 52.9%
41) Number of patients who visit an emergency room within 48 hours of attending a community physician/practice compared to peers = 52.3%
42) Type of practice (e.g. solo, group, remote, special interest) = 48% yes
43) Annual patient return visit rate (average number of visits per patient per year) = 46.4%
44) Hospitalization rates by a patient panel compared to peers = 40.9%
45) The physician rotates through many sites (e.g. locum service) = 34.5% yes

The relative ranking of these quality indicators may identify how familiar the respondent is with the actual measure, rather than an opinion about how important one measure is versus another. There may be an inherent bias due to the fact that those physicians that volunteered to be engaged in this project are probably those that have a predetermined interest in system and quality parameters.

4.3 FOCUS GROUPS

Participants of focus groups included family medicine physicians and specialists. Family practice participants included rural and urban physicians as well as Canadian and foreign trained physicians. There was great representation of physicians of all generations and gender. The setting of the focus groups was a 2-hour dinner invitation held in a private dining room of a local restaurant, with an average of 8-10 participants per group. CPSA staff included project manager Ms. Tanya Northfield, research associate Ms. Nicole Kain and project lead Dr. Ernie Schuster. The first focus group in Edmonton was also attended by Dr. Nigel Ashworth from the research and evaluation team and Ms. Donna Call, senior communications advisor. With appropriate verbal consent, focus group participants were all comfortable the conversations being taped anonymously for the purpose of capturing what was said.

Each member of the focus group research team (ES, TN and NK) independently composed a synthesis of their own research notes, comments, reflections and observations. Although differing in structure, all three members of the research team produced highly congruent summaries. These three sets of reflections were amalgamated to produce the themes listed below.

4.3.1 Themes

1. Applicability of assessment tool(s)

Focus group participants felt strongly that the tool(s) which the CPSA will develop to assess individual physicians and group/clinics, need to be applicable to and appropriate for that particular physician or group. In particular, the PAR in its current form does not apply to or is inappropriate for some specialties (e.g., palliative care). The tool(s) must take everything in context (e.g. where a physician’s practices, rural vs urban, high-income vs low-income, etc.). Results are highly dependent on patient demographics and therefore difficult to measure. Outcomes, although dependent on patient demographics and therefore difficult to measure, must be multi-dimensional.
2. **Raising the bar versus bad apples**

*Maybe we need to reframe it [PAR] as being kind of for quality improvement, one thing, and then finding, "These are the bad things."* (Female physician, Calgary, Focus Group #5)

Participants questioned what the CPSA is trying to achieve with this pilot project; specifically, two themes emerged: are we attempting to raise the bar for quality of all physicians in the province? Or, are we trying to identify / flag those physicians at risk in their practice, and in need of assistance? Is the aim to simply provide feedback, or to actually improve practice? It was generally agreed upon that one tool cannot achieve both of those outcomes and the CPSA needs to specify whether the overarching goal of this project is to raise the bar for the entire profession, or to identify at-risk physicians.

3. **Re-branding of CPSA**

*The College has a huge image problem... So I’ve been in practice for 16 years. And my experience with the College in my first 10 years was that any correspondence from them was horrible...what I’m saying is the College should hire an image consultant. Seriously.* (Male physician, Calgary, Focus Group #5)

Many participants alluded to the fact that they were wary of the CPSA, and that any formal communication from the College tends to incent fear or worry in members. Some physicians suggested that a re-branding of the continuing competence department was necessary, in order to separate this and other quality improvement initiatives at the CPSA from other departments (e.g. Complaints).

4. **Health system utilization and measurements**

*“So I think we need data. So it feels like we operate very much in silos, and we have no measurement of if we’re good or not. And, honestly, I think we have to have some measurement so that we can self-adjust because we all want to do better.”* (Female physician, Edmonton, Focus Group #1)

Participants endorsed the concept of comparative analysis. It was emphasized that a protected view of such facts be available to the physician involved, e.g. prescribing data. Physicians would be happy to learn and adjust on a voluntary basis if that information is available. More needs to be done to provide physicians with such reliable data.

5. **Physician engagement (in a broader sense beyond direct patient contact)**

*“But I think it’s -- part of it, you have to be able to, I think, give back to your community...And whatever way you do that -- I don't care how you do it, but you need to”* (Male physician, Medicine Hat, Focus Group #7)
Community service (practice related or not), engagement in hospital committees, system improvement initiatives, and service in professional organizations are good indicators for competence in a broader sense. Teaching medical students and residents also indicates broader interest and continuous learning through exposure with young learners. Physicians that are engaged in a broader sense may demonstrate more pride in their profession and an interest to be meeting professional callings outside an exam room. This may also demonstrate a more altruistic attitude as these activities may not be as well remunerated.

6. **Diligence**

*Well, especially for me, being in solo practice, I pay close attention to the quality of the consult report I get back. I pay attention to the command of English. I pay attention to what they refer to in my referral letter, whether it was confirmed or not confirmed. And just, I like to see the orderly plan.* (Male physician, Red Deer, Focus Group #2).

Diligence was identified as a quality indicator involving many traits that are important about physicians. A diligent physician will make sure that charts are completed at the end of the day and all important actions have been executed. There was general consensus that a diligent physician will show interest in panel management, proactive measures and simply said making sure that patients do not fall through the cracks.

7. **Interaction with peers**

*You know, I had never actually heard -- well, I guess I probably imagined if I hadn’t heard of a physician coming into another physician’s practice and just personally observing it for a period of time. I know (NAME) said if he had his pick, that’d be the way he would like his practice to be evaluated. I think, yeah, I’d love to have my practice evaluated like that.* (Male physician, Red Deer, Focus Group #2)

The best way to assess physicians would be direct observation by peers. The comment “I would love for an esteemed colleague to watch me in action in my practice” resonated well. The practical reality in achieving this was acknowledged, but peer to peer exposure was seen as very valuable. Participants felt that much more of these interactions need to occur and that consideration for study credits be given for such activities. Shadowing of physician colleagues (specialists or peer champions) was seen as a great opportunity to enhance clinical and administrative learnings.

8. **Team function**

Team function is an individual skill as well as a group issue. Teams may be a group of physicians, a clinic, or a virtual “team.” Physicians do work in teams,
even when working remotely or when geographically isolated, and how the team functions impacts patients. Physician team leadership is seen as a quality attribute. Teams are getting increasing importance in Family Medicine given PCN involvement. With this comes role clarification and team dynamics. Questions around team functions are important when assessing competence. Regular team meetings pertaining to the business aspects of the operation, process improvement and quality assurance should be part of the organization of a team. In facilities, QA meeting occurs to address where issues have gone wrong and that should be part of community practice as well.

9. Communication

It’s a phone call away a lot of the time. If your thing is urgent and the family physician should call the specialist to discuss the case, and then let’s then decide the urgency…the wait time. (Female physician, Medicine Hat, Focus Group #7).

There was consistent discussion surrounding the importance and increasing neglect of direct communication between physicians. Availability to pick up the phone and talk about urgent patient issues has been seen as compromised, which in turn affects quality care. A physician that will respond to a “need” is seen as a better physician as it demonstrates not only collegiality but also the sense of responsibilities to provide needed services. Referral quality, letter quality and timeliness of written communication were identified as measures of quality. Evidence of relevant communication to the family physician by an episodic clinic physician to assure continuity and follow up was seen as a quality trait for walk-in clinic physicians.

10. Record keeping

Quality and timeliness of good record keeping was often mentioned by participants. Ability to read records and for notes to make sense for other physicians who follow up is a quality issue. Having an EMR was not uniformly seen as a quality indicator although many participants believed that EMRs are better for legibility, data mining and searches for panel data. A good and updated problem list, medication profile, listing of allergies, past history and family history is important and measurable. Social data such as substance use should also be up to date. Timeliness in sending referrals and acknowledging referrals are essential. SOP may not be enforced enough in that regard. Immunization records in Alberta are seen as problematic as there is no collective record accessible to everyone.

11. MSF (Multi-source Feedback)

“But, you know, maybe focusing questions more clinically...maybe putting a common clinical scenario, and then doing focused questions on, “How am I functioning as a scholar? Communicator? Collaborator? Manager? Health advocate?” Or whatever big areas, right? Focusing questions around those big
areas and then having a peer evaluate you. (Female physician, Edmonton, Focus Group #1)

MSF was discussed as it relates to PAR but better attention needs to be directed on, “who can really tell who is a good physician?” A specialist can tell from a referral and referral letter quality who is a good physician and family physicians will form opinions about specialists based on their response and communication to a referred patient’s need. A peer in the same practice may have an opinion about their colleague based on seeing charting and exposure to other physicians’ patients. Commenting about a family physician in a different practice is more problematic. Patient feedback may very well depend on the type of practice. Coworker feedback needs to be chosen with great care.

12. CPD (Continuous Professional Development)

Continuous professional development (CPD) is monitored by the College, but the relevance of said CPD to physician practice is not. Participants felt that competence is in part related to the kind of CPD that physicians choose. Is it relevant to practice; is it relevant to learning needed / updates in clinical content? Does it have a component of administrative learning and leadership training? CPD credits should apply for physician shadowing (those that shadow and those being shadowed).

13. Time spent with patients

Participants repeatedly identified that high volume operations may not achieve quality care. Unfortunately the system does not incent low volume care. Spending time with patients, when feasible, is seen as a quality indicator. Encouragement for a relationship with a primary care physician should be part of an episodic visit and mentioning of the need for preventative care. Improvement initiatives however will not sanction the concept of running late with patients as it is often a result of inadequate planning (“truth in scheduling”). In other words, if a physician knows that he or she will take a certain time with patients on average that should be factored into the schedule so delays do not happen.

14. Compassion

“...it’s not just the communication which is important, but the sense that the practitioner enjoys patients, enjoys their work, enjoys seeing people. So that enjoyment in human interaction is something that’s hard to select, and how do we promote it? Because I think successful doctors enjoy patients, and they enjoy the encounters... basically, that respect and enjoyment in the human interaction is something that’s hard to quantify, but that’s one of the things that I look for.” (Female physician, Edmonton, Focus Group #6)

Compassion is difficult to measure. Compassion and advocacy were debated frequently and seen as important quality traits. It would be good to find
surrogate indicators that indicate these softer issues; MSF may be the best way to probe this trait.

15. Access and after hour availability

“I think structures and process would be the first things to look at ...” (Female physician, Calgary, Focus Group #5).

Participants felt that appropriate access for care may be a systems issue but also an organizational /administrative issue. After-hour access is a Standard of Practice (SOP) but the quality of that availability defines a good physician. Just sending a patient to the ER without attempting to avoid that encounter was not seen as quality care. Access and continuity can be improved with tools offered by AIM. There was some mention that physicians have to hold patient’s responsible for their expectations as well.

16. The consequence of saying “No”

If you’re really loose with your [prescription] pad, you can get five stars. (Male physician, Lethbridge, Focus Group #3).

It was recognized that a good physician will resist unreasonable expectations in regards to referral demands, prescribing restricted substances and antibiotics and ordering tests. It was recognized that a physician who pleases everyone every time may have issues. There is not enough support for the profession in learning best ways to resist unreasonable demands. Not saying “No” when appropriate may be due to personal weakness or an exit strategy to see more patients.

17. Episodic care

In remote rural settings where panel limits are simply not a choice due to lack of professional resources episodic care may be the sole option; in these cases a family physician may fulfill the role of an emergency physician. Communication with the primary provider to assure follow up and continuity is a quality trait for an episodic physician. Spending time to have the patient feel that it was a worthwhile visit and mentioning the need for the establishment with a primary care provider when not existing, was discussed.

18. Work-life balance

“I think that is a good measure of a good physician is the physician that knows when to say no; when the physician that is willing to take care of themselves... “ (Female physician, Medicine Hat, Focus Group #7).

Participants felt that appropriate work-life balance was an important issue. Physicians that take care of their physical and mental needs will likely be better physicians. A balanced approach to work and family time needs to be explored.
Physician health may not be achieved by working an unreasonable number of hours or by attempting to meet unrealistic expectations from multiple sources.

19. CPSA and system issues

Health system issues were often discussed and CPSA’s role in addressing them, as well as acting as an advocate in such issues on behalf of physicians. It was felt that CPSA should have a voice in system financial issues if such issues touch on physicians’ ability to provide quality care. Participants suggested that it would be better to not segregate practice and physician assessments, and that 5 year intervals between assessments may be too long. Some felt that yearly reflections on a smaller scale would be better. The annual RIF could be expanded to capture quality elements (e.g., it could serve as an annual screening tool to help identify at risk physicians).

20. CPSA must improve support to physicians

“I’m wondering if it would be more meaningfully... if doctors identified an area they would like to feel more confident, that they would like to measure their improvement, rather than being this global kind of ‘How are you doing across the board’... and is there an external way that you could provide me the resources to embark on that as you suggest?” (Female physician, Edmonton, Focus Group #6).

Rather than provide physicians with guidelines, participants want the College to provide specific advice and resources on how to adhere to SOPs. The College should collaborate with other stakeholders to support physicians with issues related to resources and money. Support physicians with disabilities; support physicians who are near retirement. There was a sense that the CPSA has no means to enforce SOPs. Physicians must understand the consequences of not adhering to SOPs and CPSA must follow-up with physicians to ensure compliance.

21. Feedback

Participants mentioned several methods of feedback which they considered to be valuable: In-person feedback from a colleague; on-site clinic visits – voluntary or mandatory. Physicians in northern Alberta particularly have challenges related to CME credits (lack of opportunities, cost); therefore a voluntary on-site visit with a colleague for CME credits would be valuable. Other desired methods of feedback included direct observation and chart audits; random MSF; random chart reviews; and observation by a colleague or peer. With regard to group practices, physicians identified and supported the need to look at other physicians within their practice group. Family physicians and specialists should assess each other (particularly in smaller communities where physicians work together closely), or physicians should be provided with feedback from other non-medical staff. Colleagues are often not the best to assess or provide feedback.
4.3.2 Quality Indicators

In addition to the above themes, focus group participants identified various quality indicators for physicians, some of which reflect those listed in Survey #2. Indicators for quality medical practice identified in focus groups include:

1. Ability to communicate effectively (with patients, colleagues, etc.)
2. Access to Netcare
3. Work-life balance (including self-care)
4. Being involved with teaching (e.g. supervising medical students/residents)
5. Having business skills (to effectively run a practice)
6. Charting (that another physician can understand)
7. Being collaborative (working with others, other groups, etc.)
8. Compassion (difficult to measure; but may be seen through diligence and engagement)
9. Confidence
10. Continuity of care
11. Diligence (e.g. following through with test results, following up with patients)
12. Engaged with patients (rather than just working with EMR)
13. Low error rates on diagnostic tests
14. Good medical lists and records
15. Knowing patients’ names, history, etc.
16. Demonstrated leadership
17. No complaints against the physician (although recognize this not always reliable)
18. Patients understand their condition and medications (demonstrates good rapport in GPs)
19. Physicians who accept phone calls
20. Processes and structure most important
21. Quality of referral letter (both writing referrals and/or receipt of /response to referrals)
22. Good record-keeping
23. Being reliable
24. Being respectful (to patients, colleagues, staff, and etc.)
25. If physician often runs late – could mean that they are spending quality time with patients
26. Specialist efficiency with referrals
27. Specialists can determine quality through their communication with physicians
28. Structures, processes, outcomes and context
29. Takes on-call, home visits, etc.
30. Good team / clinic function
31. Willing to take medical students and or residents

Focus group participants also identified items which they considered not to be indicative of quality: EMR is NOT a quality indicator; as there are many excellent
physicians with good paper charts. Having hospital privileges is NOT a quality indicator.

Participants were asked to give their feedback on the focus groups: 90% felt the session was easy to participate in; 81% felt the session was well organized; 75% felt the discussion topics were valuable; and 86% of participants felt their thoughts and ideas were heard.

4.3.3 Stakeholder Consultations

The project lead and project manager met with various stakeholder groups including AIM Steering Committee, Primary Care Alliance, AMA-AHS Joint Venture Committee, South Anderson Primary Care Association, HQCA, TOP, Department of Family Medicine – University of Alberta, the Section of General Practice Executive Committee, the Alberta Chapter of the College of Family Physicians, and the College and Association of Registered Nurses of Alberta (CARNA). There was great interest and support in the CPSA’s project. At all times it was recognized that we were unified by the common goal of good quality patient care and improved process.

Stakeholders in general welcome a redesign in physician assessment. The emphasis on useful, timely and appropriate feedback, inclusion of quality and process improvement as well as self-reflection was highly endorsed. There should be no duplication of initiatives but rather integration, as physician members are overburdened with initiatives. Working together cooperatively and efficiently in achieving common goals was endorsed and highly supported. An important issue is the separation of complaint and major deficiency issues from the quality initiatives that serve the broader physician population. Physician involvement in process improvement initiatives, system improvement and awareness of the “bigger picture” of a health professional’s raison d’être was endorsed throughout as a quality indicator. Diligence attributes and system utilization were identified as important items. Some stakeholders also commented on their perceived lack of SOP enforcement by CPSA, in particular to issues around referrals and after hour “on call”.

Stakeholders were impressed and pleased that CPSA Council has endorsed the concept of the “medical home” and surrounding supportive initiatives. The College’s contribution by “pulling on the same rope” promoting these initiatives was highly welcome. Ongoing coordination and awareness of quality initiatives was supported and is in part achieved by CPSA staff membership at steering committees. Partner organizations welcomed support for their projects and the mentioning of resources they offer in assessment feedback. Ongoing communication was desired as the pilot project evolves and these stakeholders are interested being kept in the loop and to provide further feedback. Stakeholder consultation is an ongoing process (as of January 2016) as we plan to continue discussions with stakeholders and follow-up with further information and request for feedback moving forward.
5. **Conclusions & Next Steps**

In response to Council’s direction in May 2014, the pilot project engaged positively with physicians and the preliminary results confirm the profession’s desire to redesign and improve the process which regularly reviews physicians.

Through all methods of engagement/data sources, physicians regularly identified:

- The needs and benefits of being assessed both as individuals and within their group practice;
- The importance of recognizing other quality improvement activities and ensuring there is no duplication; and
- Collaborating and communicating with other partners and stakeholders, including but not limited to their colleagues and peers.

Results of the surveys, focus groups and stakeholder consultations will be incorporated into the general assessment redesign.