APPENDIX C BASE FAX SURVEY

Scope of practice

1. Please indicate which of the following types of services you provide to individual patients
(Please check the box to indicate yes, and feel free to add comments to explain your answers).

Type of service		Comments
a) Care for an emergent but minor problem (e.g. sprained ankle, unexplained rash)	◯ Yes	
b) Non-urgent care (e.g. well woman care, episodic care, continuous care of chronic disease)	◯ Yes	
c) Rehabilitation services (e.g. specialized injury follow up such as Sports Medicine)	◯ Yes	
d) Minor office procedures (e.g. sutures, skin biopsy)	◯ Yes	
e) Pre-natal maternity care (alone or shared)	◯ Yes	
f) Intrapartum care (attending deliveries)	◯ Yes	
g) Postpartum care (in-office follow-up)	◯ Yes	
h) Behaviour change counselling about tobacco use	◯ Yes	
i) Behaviour change counselling about healthy eating	◯ Yes	
j) Behaviour change counselling about physical activity	◯ Yes	
k) Other health promotion or prevention services	◯ Yes	
l) Mental health services	◯ Yes	
m) Psychosocial services (e.g. counselling advice for physical, emotional, financial problems)	◯ Yes	
n) Liaison with home care services	◯ Yes	
o) Provision of home visits	◯ Yes	
p) Outreach services to vulnerable/special populations	◯ Yes	
q) Specialized programs (other than outreach services) for vulnerable or special needs population groups, e.g. seniors, adults with disabilities	◯ Yes	
r) End of Life home care	◯ Yes	
s) Primary Care in long-term care facilities	◯ Yes	
s.1) Only for those patients from your practice?	◯ Yes	
t) Community Outreach (e.g. School youth health centres, mental health clinics, correctional facilities, well-women clinics)	◯ Yes	
u) Emergency Department	◯ Yes	
v) Collaborative Emergency Centres	◯ Yes	
w) In-patient hospital care (for your patients in a hospital)	◯ Yes	
x) Other, specify_____	◯ Yes	

2. Which of the following payment methods apply to you?

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(Please tick all that apply and indicate an estimated corresponding percentage.)

Payment Method	Applicable?	What %?	Notes
a) Fee-for-service?	◯ Yes	%	
b) Salary	◯ Yes	%	
c) Capitation	◯ Yes	%	
d) Sessional/per diem/hourly	◯ Yes	%	
e) Service contract	◯ Yes	%	
f) Incentives and premiums	◯ Yes	%	
g) Blended	◯ Yes	%	
h) Other, specify_____	◯ Yes	%	

3. Do you have hospital privileges? ◯ Yes ◯ No

3a. If yes to 3, please specify where and type:

4. Are you currently accepting new patients? ◯ Yes ◯ No

4a. If no to 4, are there exceptions? ◯ Yes ◯ No

4b. If yes, there are exceptions, what are the exceptions?

◯ Family member of current patient ◯ Pregnant women ◯ No family doctor

◯ Other, please specify _____

5. Do you require a "meet and greet" appointment with new patients? ◯ Yes ◯ No

5a. If yes to 5, after this meeting, does the patient ever decide not to continue seeing you?

◯ Yes ◯ No

5b. If yes to 5, do you ever decide not to continue seeing the patient?

◯ Yes ◯ No

Comment:

6. Would you accept new patients requiring narcotics? ◯ Yes ◯ No

Comment:

7. Do you have a policy that you will only address a limited number of issues per appointment?

◯ Yes ◯ No

7a. If yes: ◯ **1 issue** ◯ **2 issues** ◯ **3 or more issues**

8. In the past 12 months, about how many working <u>days</u> <u>in total</u> have you been away from the practice due to:

a) Attending conferences or other educational activities?	days
b) Committee/Administrative activities?	days
c) Research Activities?	days
d) Vacations?	days
e) Illness?	days

9. In your absence, what arrangements are made for your patients?

10. Is there an e-mail address where you would respond to patient questions? ◯ Yes ◯ No

11. How is this practice governed/managed? (*Check ONE*)

◯ Provider-led Private Business
◯ Non-Provider-led Private Business
◯ Community Board
◯ District Health Authority
◯ First Nations
◯ Other. Please Specify_____

12. If you are in a group/joint practice…Do members of the practice team use any of the following mechanisms to support collaboration within the team? (*Please check the box to indicate yes, and feel free to add comments to explain your answers.)*

		Comments
a)	Informal or ad hoc exchanges	◯ Yes
b)	Regular team meetings for organizational administration	◯ Yes
c)	Regular team meetings for case management	◯ Yes
d)	Pre-established care protocols for specific client groups or problems	◯ Yes
e)	Shared vision for the practice	◯ Yes
f)	Team building sessions or workshops	◯ Yes
g)	Joint continuing education sessions	◯ Yes
h)	Collaborative practice arrangement	◯ Yes
i)	Written roles and responsibilities of team members	◯ Yes

13. Do you use a computer in your practice for the following purposes? *(Check all that apply.)*

◯ ***Not applicable (I do not use a computer)***
◯ Making appointments
◯ Issuing drug prescriptions
◯ Electronic warning for adverse prescribing and/or drug interactions
◯ Specialist consultative report

◯ Sending referral letters to medical specialists
◯ Storage of diagnostic test results
◯ Searching medical information on the internet
◯ Sending prescriptions to the pharmacy
◯ Quality improvement
◯ Electronic records to enter and retrieve clinical patient notes
◯ Electronic reminders for recommended patient care
◯ To prompt calls for patient follow-up

14. What is the (estimated) size of your practice population? (In a joint practice: estimate your share of the population). If you do not have a formal list, please estimate the number of patients that normally rely on you for primary health care.

15. On average, how many hours per week do you work as an office-based FP/GP/NP (excluding additional jobs and on-call)?
_____ # of hours per week at your main practice

16. How many of these hours per week do you spend on direct patient care (in person consultations, telephone consultations)?
_____ # of hours per week at your main practice

17. Do you provide evening care at your main practice? ◯ Yes ◯ No

18. Do you provide weekend care at your main practice? ◯ Yes ◯ No

19. In what language(s) are you able to provide patient care?
◯ English ◯ French ◯ Other (please specify) _____

20. When do you plan to retire?
◯ Within the next year ◯ In 1-2 years ◯ In 3-5 years ◯ In more than 5 years

Future Research
21. May we contact you in the future to request your participation in further research?
◯ Yes ◯ No

Signature_____(Please print your name.)_____
Date_____

Thank you for your participation. Your survey responses will be anonymous in accordance with the confidentiality requirements of the Capital Health District Authority Ethics Board. If you have any questions or concerns about the study, you can contact the Principal Investigator, Dr. Emily Marshall, at 902-473-4155.