

THE FUTURE OF PRIMARY CARE

Member Feedback from Regional
Virtual Engagement Sessions 6 to 9
July 6, 7, 13 & 14, 2022

WHAT WE HEARD

What is the goal of this engagement?

Through June and July 2022, Doctors of BC members were invited to provide input into solutions to address the challenges in primary care. Member feedback will form the foundation for tangible, concrete actions that Doctors of BC will take forward to government.

How did we seek member input?

Nine virtual discussion sessions were held between June 22 and July 14, 2022, organized by health region. This report summarizes general themes heard from members during sessions six through nine held between July 6 and 14. A summary of general themes heard at the five previous member engagement sessions [can be found here](#).

Feedback collected from an additional session held for graduating/new-to-practice Family Medicine Residents as well as from our online "Have Your Say" platform will be shared when available. A further in-depth analysis of all member feedback from all aspects of the engagement effort will help to determine priority actions for our organization and to move forward to government.

Who participated? Four online virtual sessions

TOTAL PHYSICIAN PARTICIPANTS: 172

(includes 1 to 3 Doctors of BC/GPSC physician leaders per session)

Island Health Session:
(July 6): **26**

Vancouver Coastal Health
Session (July 7): **78**

Fraser Health Session
(July 13): **41**

Interior Health Session
(July 14): **27**

DEMOGRAPHICS

Based on optional poll responses from 168 participants

Role

Family Physician (FP): **87%**
Consultant Specialist: **13%**

FP participants working in longitudinal practice

Yes: **73%**
No: **12%**
n/a: **15%**

Practice location

Urban: **79%**
Rural: **20%**
Remote: **1%**

Primary mode of payment

Fee For Service: **79%**
Population-based-funding: **1%**
Salary: **4%**
Session: **4%**
Service Contract: **12%**



Stage of Practice

5 years or less: **11%**
6-15 years: **29%**
16-25 years: **24%**
25+ years: **36%**

DISCUSSIONS AND THEMES

Part 1: Value and Compensation questions

▶ What short term actions could help keep family physicians in longitudinal care?

Members continued to articulate the urgent need for additional resources to dramatically and strategically reduce current workloads and costs associated with operating family practices. Identified resources include financial, personnel, and healthcare system-wide supports, including increased access to team-based care.

▶ What are some ways we can better demonstrate the value of the work of family physicians?

Members articulated the need to further raise awareness for the value of longitudinal community-based family practice with key stakeholders and partners involved in primary care service delivery (Ministry of Health, health authorities, allied health partners, and others).

FPs should be valued for the work they do in creating relationships and trust with patients and connecting them with the broader health care system, and the personal time they sacrifice to provide quality care — all while ensuring the viability of their practice.

▶ What are characteristics of any potential new payment model that would support you in the way you would like to practice as well as ultimately support the system improvements needed?

Members re-emphasized a collective interest in having decision-makers land on a suite of payment models with options, that consider and support the unique needs of individual physicians, diverse communities, and myriad of services.

Members identified the benefits and constraints of existing models including fee for service (FFS), contracts, and others. Many FPs are unsure about pursuing current contracts. Concerns include balancing patient volumes with workflow, time, and compensation constraints, and the role of the health authorities in managing contracts.

FPs are interested in having access to benefits and pensions for themselves and their MOAs.

▶ Themes heard in 'Value and Compensation' discussions (not in priority order)

COMPENSATION

Infrastructure (overhead)—

Advocate for funding to stabilize primary care at the practice level. Focus financial supports on drastically reducing overhead, operating, and personnel costs for FPs with longitudinal primary care clinics. Significant overhead costs in both urban and rural areas have become a barrier to operations and long-term sustainability of practices.

- Ensure any new financial supports reflect present day operating costs, are competitive in the current labour market, and increase with inflation.

- New funding opportunities should not create unrealistic expectations, workload, or responsibilities.

Compensation for indirect

care—Immediately support and reduce the inordinate amount of unpaid indirect care work done by FPs, compounded by increasing numbers of patients and complexity of health needs.

- Pay FPs for required additional time to complete care-related work: administration tasks, paperwork, charting, on call, and after-hours care.

IN YOUR WORDS

"Value the role of the family physician; the foundation to the health system." — Island Health

"With respect to value, we are looking at the whole person. This results in fewer referrals, fewer ER visits, fewer hospital stays, and fewer repeat visits and low value care." — Interior Health

"I have saved lives and been paid \$30 for that: is that being valued?" — Fraser Health

"If our jobs were valued higher, then people would come." — Vancouver Coastal Health

Fee for Service issues— Urgently increase the base rate to appropriately reflect current day costs. Members commonly agree that current fee levels are at minimum, “a decade behind current day cost levels.” Existing limits on current billing remain a concern.

- Better compensate for time spent with patients: add time modifiers as a strategic solution.
- Eliminate the 50% “discount” for additional services that do not appropriately reflect ongoing care requirements. (e.g., “How do you do just half a Pap?”)
- Change the approach and simplify fee codes for more complex cases. Broaden patient diagnosis and criteria for complex care.
- Address the inequity in fee codes for counselling and mental health supports.
- Decrease the cognitive/time burden on FPs by simplifying MSP and fee codes overall.

Payment models— Better align payment models with various roles and functions of a clinic, as FPs practice in a variety of ways (full time, part-time, etc.) with the need to support overhead.

- Existing options of Ministry contracts or FFS are not sufficient to meet practice needs or retain FPs.
- Taking on new patients is not realistic nor enticing due to already unmanageable patient panels and overburdened staff.
- Current contracts do not offer part-time options for FPs with families, or maternity leave, significantly impacting career choices.
- Recognize value for preventative care in the family medicine compensation model.

Virtual Care/Telehealth—Incentivize virtual care when performed by longitudinal FPs, to recognize the value it brings to the system when linked to longitudinal care.

Equitable remuneration— Ensure models of payment are equitable to accommodate the different needs of FPs, whether they are clinic owners or associate providers.

Incentivize FPs to practice longitudinal care by recognizing the intensity, time, ongoing commitment, and complexity required to do the work in relation to episodic care or time based hospitalist work.

- Compensate FPs appropriately as the most qualified people to provide primary care.
- Do more to address the differentiation between specialists and family doctors in terms of workload and value to patients and the system.

Negotiations— Increase communication, transparency, and information about PMA negotiations — including DoBC’s priorities for negotiations — to allow members to better understand tangible outcomes being negotiated, and to confirm they will have the impacts needed to sustain family practice.

GOVERNANCE / SYSTEM

UPPC-related challenges—Value FP work on par, if not above, to that of Hospitalists and UPCC work.

- UPCCs are causing a significant divide among longitudinal primary care providers. New-to-practice FPs are choosing UPCCs for better wages, benefits, and no overhead.
- Address the issue of UPCCs draining local area talent pools including MOAs, which impacts clinic operability, team morale, and sustainability.

Part 2: Addressing Cumulative Burdens questions

▶ What short-term action would help you reduce areas of burden?

▶ What are examples of burdens you experience that you think could be eliminated or drastically simplified?

Members are experiencing moral distress due to the accumulation of burdens, which take time away from patient care and reduce capacity for new patients.

Members identified burdens that could be alleviated, and additional supports that could help. Concerns focused on unnecessary, or labour/time intensive tasks associated with the increasing volume and complexity of forms and other paperwork-related tasks, billing fees,

▶ As we consider stabilization of practices, what resources would help you address burdens?

▶ Help to prioritize resources to best reflect your current need.

and referrals. Poor access to necessary services and supports for patients is also a key concern.

Many ‘asks’ of an FP’s time beyond their traditional role negatively impacts their ability to see more patients and complete their workday in a reasonable amount of time.

More barriers exist for women, and a large percentage of female FPs leave in the first five years of practice. A focus on these needs would be beneficial.

Themes heard in 'Addressing Cumulative Burdens' discussions

(not in priority order)

PHYSICIAN SUPPORTS

Locum coverage— Fund a robust, easily-accessible locum pool to support the urgent need of longitudinal FPs to take time off for illness, family needs, vacation, professional development, and/or maternity/paternity leave — and to retain FPs.

Locum contracts should support the needs of both the locum and host physician.

Remunerate locums appropriately to support their challenges, including child care, uncompensated travel time, etc.

FP/Specialist collaboration—

Increase communication and collaboration, and clarify processes between providers to enhance relationships and better meet the needs of patients.

Establish clear and appropriate guidelines around referrals to help advance appropriate care, reduce wait times, and simplify practice workflows.

Address challenges of specialists “offloading” tasks onto FPs, such as ordering and following up on specific recommended tests.

ADMINISTRATIVE SUPPORTS

Administrative tasks— Reduce, eliminate and/or delegate burdensome tasks to reduce demands on time and allow FPs to focus on patient care.

- Simplify tasks and processes including billing, forms, notes, referrals, and re-referrals.
- Delegate operations and office management work to others who are trained, experienced, and better suited to manage administrative work.

- Provide financial resources to attract, train, and retain additional office/staff supports to manage a variety of daily tasks such as completing forms, and daily communications. Rural practices may have reduced access to required additional supports.
- Increase HR supports to effectively maintain staff, and to plan for better pay and benefit options, so that FPs can compete with other employers.
- Revisit the current required forms and communications systems with pharmacists, with a focus on shifting responsibility for Special Authority Forms to pharmacists or eliminating them altogether.

Training— Explore the training burden and numerous requirements needed to remain compliant; such as privacy, HR development needs, IT systems, managing conflict, etc.

Technology— Secure, centralize, and fund skilled support for IT and EMR operations, instead of expecting FPs to take time away from direct patient care for training to manage clinic-related IT needs and business/operations systems.

- Coordinate EMR interoperability, enhanced features (e.g. instant messaging), and effective training and support.
- Address inequitable technology costs between FPs across health regions.
- Streamline and update technology. Move away from antiquated technology (fax machines) and reduce silos of information.

IN YOUR WORDS

“Physician wellness = patient safety. This needs to be recognized.” — Island Health

“Physicians of 20 years are leaving practice to become Hospitalists due to rising costs and overheads.” — Fraser Health

“Our inability to secure locums is affecting all stages of practice” — Interior Health

“I do this unpaid work either at 5 in the morning, or between 9 and 12 in the evening after the kids are already in bed.” — Fraser Health

“Most patients cannot afford a counsellor of psychiatrist, so we take on that burden unpaid because we cannot say no.” — Vancouver Coastal Health

“All the forms are taking away from my time looking after patients. Show value by enabling us to do medicine.” — Fraser Health

“We watch and feel helpless as patient wait times increase to access supports, beds and services.” — Interior Health

“Why is primary health care any less important than education? If we had 10,000 kids without teachers something would be done about it. There are over 900,000 British Columbians without care.” — Vancouver Coastal Health

“Support the people doing the work.” — Island Health

PATIENT MANAGEMENT

Team-based care— Revisit the approach of team based care to ensure effective implementation, and to provide sufficient and better supports to family practices. The need for diversified skillsets and supports for increasing patient and community needs remains high.

- Further develop and fund additional allied health resources including NPs, RNs, mental health professionals, and prompt access to social workers.
- Diversify care teams to include home care supports, occupational therapists, physiotherapists, therapists, counsellors, and others who are regularly required to meet patient needs.
- For team-based care success, ensure that every member of team is valued and recognized appropriately for their skills and contributions—including FPs.

Specialized supports— Increase patient access to critical resources such as labs, medical imaging, and mental health and substance abuse supports.

Physician networks— Work to establish provincial-level clinical networks with supports, to reduce FP isolation and increase connections that can help support the efficiency of patient care.

Enhanced MOA role— Fund support for the MOA role and functions, which is multi-faceted and involves patient frontline duties. FPs should be able to delegate tasks and duties to MOA staff, and bill for them.

- Revisit the “super MOA” concept with additional training. Elevate existing MOA roles to assist FPs with more complex and time-consuming tasks and duties, taking patient histories, billing, scribing and other documentation.

Virtual care— Explore ways to seamlessly integrate telehealth/ virtual care into primary care practices, and to establish appropriate levels of care and fair and effective processes (wait times, referrals, etc.).

- Address tensions between family medicine clinics, walk-in clinics, and episodic providers of virtual care.
- A climate of competition for financial supports, personnel and other resources that has developed in virtual care.

PRACTICE REQUIREMENTS

College guidelines and standards— Acknowledge that more collaboration is needed to address the disconnect between FPs and the College— to ensure expectations are more realistic and respectful, and do not increase burnout during an already difficult time, or contribute to FPs’ distress and inability to effectively operate.

- The current licensing process has barriers and complications and is too lengthy. Members report a six-month to two-year wait and question why other province’s colleges are more effective.

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