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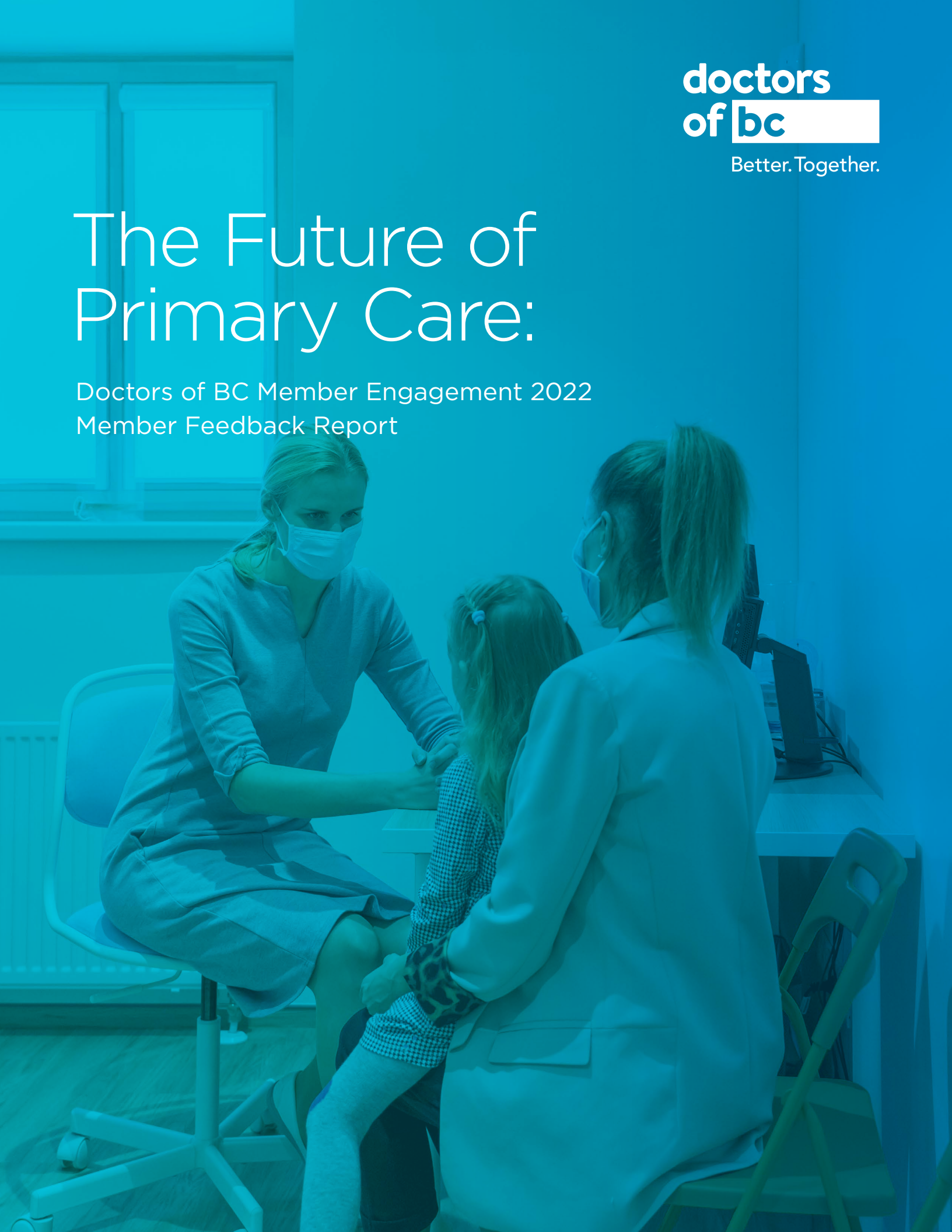
The Future of Primary Care:

Doctors of BC Member Engagement 2022 Member Feedback Report



Member feedback report: themes and solutions

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Executive summary

In June and July 2022, Doctors of BC invited all family physician and specialist members to participate in a major, province-wide consultation on the future of primary care.

We wanted to better understand and address serious concerns that family physicians have been raising about the survival of longitudinal family practice in BC communities, and the ripple effects of the primary care crisis across the system. Family doctors have been leaving the profession, and many new-to-practice doctors are avoiding longitudinal family practice and pursuing alternative career paths. As a result, almost one million British Columbians do not have a family doctor, and are not getting the quality of care and access to care that they need and deserve.

In May 2022, our President Dr Ramneek Dosanjh, Board Chair Dr Adam Thompson, and senior staff met with Premier John Horgan and Health Minister Adrian Dix. They spoke about the key issues for family doctors – including rising business costs and the many administrative and other burdens that are causing unprecedented stress and burnout. At that meeting, the Premier asked his Deputy Minister Stephen Brown to sit down with Doctors of BC and develop solutions to help attract and retain physicians into longitudinal care.

In addition to the input received over many years from our members, Doctors of BC immediately embarked on a major member engagement involving family doctors and specialists to seek their input on concrete practical solutions to the primary care crisis over the short-, medium-, and long-term.

Member feedback was summarized regularly throughout the process, so that learnings could be incorporated into the real-time discussions with government. Full member input – summarized in this report – will provide a key resource for ongoing planning and direction of the Association.

Physician voices

Between June 20 and July 20, 2022, Doctors of BC members, including recent family practice graduates, weighed into 10 dynamic virtual discussion sessions as well as online on our Have Your Say platform to give us feedback about the challenges and concerns they are facing; but even more importantly, their proposed solutions.

Family physicians and specialists from right across BC came together to share their unique stories and lived experiences navigating day-to-day work in primary care and in their clinics. They expressed their deep commitment to their patients and communities, and their exhaustion and frustration with the challenges they are facing. They passionately articulated hopes for a better future, along with solutions and ideas that would help them continue to practice in the work they love.

Overwhelmingly, and fundamentally, members told us that physicians providing community-based longitudinal care need to be valued for their central role in a patient's health journey, and for the sustainability and efficiency of the health care system itself.

They emphasized that family physicians should be valued for their qualifications and the work they to do to provide quality care, create relationships and trust with patients, and to connect patients with the broader health care system; and for the personal time they sacrifice to do so, while ensuring the viability of a practice.

What you told us:
Participation

Member opportunities: 3 ways to participate from June 20 to July 20, 2022

A mix of dynamic, virtual discussion sessions and an online platform enabled physician members to share their key concerns, insights, burdens, priorities, ideas, and solutions.

Nine facilitated virtual discussion sessions held between June 22 and July 14, 2022, across five health regions— Vancouver Coastal, Fraser, Island, Interior, and Northern Health that included 360 physician participants.

Doctors of BC online Have Your Say platform – with three discussion forums and a question and answer tool – that saw 2,500+ visits between June 20 and July 15 and resulted in 714 comments from 317 participants. It also captured additional specialist perspectives.

A focused session for recent Family Practice graduates (R2 Residents) and new-to-practice family physicians held on July 20 with 85 participants who joined a facilitated session to answer questions, and share concerns and aspirations for a career in family medicine and primary care.

What you told us:
Challenges

Family doctors told us about daily burdens they experience that take time away from patient care and lead to burnout, including administrative tasks, and unpaid paperwork and forms that have them working late into the evening.

Members confirmed that inflated lease and overhead costs in urban and rural communities jeopardize the ability of many practices to keep their doors open, and significantly impact their earnings. Some family doctors noted that their hourly rate after overhead works out to less than their MOA's, dog trainers, and repair people.

Overall, adequate compensation for patient care has fallen far behind current realities, complexity of care, and inflation.

Family doctors struggle to access the supports, specialty care, and investigations that their patients need, and say that team-based care is just not happening fast enough. The escalation of mental health challenges is a crisis on its own, but available specialty care is woefully inadequate.

Rural doctors flagged many additional and unique challenges they encounter when arranging for patient supports and running their practices.

Specialists joined the discussions and offered heartfelt support for their primary care colleagues. They shared stories about the effects of the crisis in their own work, hospitals, and clinics, and the increasing pressures they are under to support patients who do not have a family doctor.

Family practice graduates, as the doctors of the future, shared their hopes and aspirations for a fulfilling career in family practice – where they can look forward to practising medicine in a healthy and balanced way, and spend more time with patients instead of being overwhelmed by administrative tasks and paperwork.

See page 16 for a summary of challenges/burdens heard from members.

What you told us:
Solutions

Participants spoke eloquently and passionately about solutions, which are summarized in the report that follows. Some recurring themes include:

Pay family doctors fairly and equitably for the work, time, and costs involved in providing longitudinal care. Provide appropriate compensation that is also equitable with other options, pay for indirect care so there is no more unpaid work, and support overhead. Overall, work to increase net income after overhead for family doctors.

Offer optional, flexible payment options through improved fee for service with time modifiers or updated contracts. Provide choice in how family doctors are paid to reflect the different ways they practice, and that maintains physician autonomy so they can best serve the needs of their patients and communities.

Review billing fees. Expand fees for complex medical conditions, augment fees where inadequate for the work required, and simplify fees in other areas to be easier to use.

Reduce administrative tasks and forms. Streamline, simplify, or eliminate paperwork and forms, and pay doctors to complete them. Reduce the growing burden of responsibility on family doctors to fill out legal and insurance forms.

Support escalating costs of rent and overhead. Seek solutions to address inflation, rent/lease increases, and associated overhead costs.

Provide business supports for practices. Provide training and administrative supports for clinic and business operations, training, and technology. Expand the MOA role for more patient care support.

Increase access to locums. Arrange for a centralized, easy-to-access locum system to support doctors when they need take time away from the practice.

Increase patient supports. Urgently expand team-based care, mental health supports, specialized care, and access to services needed for investigations.

Improve family physician and specialist collaboration, communication and processes, and overhaul the referral system to reduce burdens on family practices and improve patient experiences.

Fund, centralize, and modernize technology and electronic medical records (EMRs). Create an accessible, easy to use, interoperable EMR system to save time, and improve communication and care quality across settings.

See page 18 for a summary of solutions heard from members.

What's next?

Doctors of BC continues to work with government on the development of a new payment model. It is anticipated an announcement will be made in October 2022. The input from the engagement has been critical in shaping the direction and outcome of this work.

The findings have provided invaluable information and perspectives in the negotiation of a new Physician Master Agreement, which is also anticipated to be concluded in the near future.

Work has already started on steps to relieve the burdens on physicians, and input from the engagement will play a major role in defining next steps and future actions to address this significant challenge.

The findings will continue to provide a basis for strategic policy, decisions, and actions as we continue to address the ongoing challenges in our health care system.

Doctors of BC is committed to continuing to engage with our members on a regular basis. We will keep you posted regarding developments and progress, as well as future ways to ensure your voices are heard.

Doctors of BC extends our heartfelt thanks to everyone who participated in the engagement either in discussion groups or through our web platform. Thank you for your honesty, your passion, and your thoughtfulness. The input you provided has provided us with a strong foundation for our work with government to develop timely solutions, and it will also provide us with a pathway forward for many years to come.

Background: The Primary Care Crisis

Physicians who provide longitudinal care are the foundation of our primary care system, and patients who have a regular family doctor – someone who knows them and their health history – have better lifelong health and use fewer health care resources.[1] Yet almost one million BC residents don't have a family doctor, and are challenged to reliably access timely primary care and the related specialty supports and services they need.

Family physicians are distressed that they can't to do more for residents and their communities. In their own practices, they are faced with an accumulation of burdens that take time away from direct patient care and limit their ability to see new patients. They are struggling with escalating rent and overhead costs, administrative tasks and paperwork, and inadequate supports for complex patient care – all amplified by the pandemic.

Family doctors are more exhausted than ever. Feeling devalued and frustrated, they have serious concerns about the sustainability of their practices, the future of longitudinal family medicine in BC, and their own career and health. Some are losing hope, burning out, or leaving the profession – while many new graduates are reconsidering a career in longitudinal family practice.

Many feel the recently emphasized additional expectation of 24/7 coverage is unrealistic for their well-being. When they want to take a break from their practice for personal, family, or business needs, they are challenged to do so, as many can't find locums to cover for them.

System impacts

The impacts of the primary care crisis and decline of longitudinal family medicine are felt through the entire health care system, including in emergency rooms and by specialists.

Specialists noted a number of impacts of the primary care crisis, such as unattached patients using emergency departments inappropriately, getting readmitted without post-discharge follow-up, and missing medication renewals.

While progress has been made through Doctors of BC and the GPSC to support family practices and primary care, and collaborate on team-based care – it is not enough.

More needs to be done to realistically meet the current and future needs of patients, to retain and recruit doctors, and to shore up an overburdened primary care system.

The need to listen to members, to take action

In June and July of 2022, Doctors of BC embarked on a major, province-wide consultation with all its physician members on the Future of Primary Care. We needed to hear directly from family physicians and specialists about their lived experiences working in the system to clearly understand and identify their issues. We made a commitment to use the feedback to inform concrete, priority actions for Doctors of BC as an organization and to move forward to government.

[1] Starfield B., Shi L., Macinko, J., Contribution of Primary Care to Health Systems and Health; The Milbank Quarterly 2005; Sep; 83(3): P457–502

Member consultation planning and goals

In the Spring of 2022, the Doctors of BC assembled a leadership and project team with its President, Board representatives, Executive members, physician leaders, and staff to contribute to the design and implementation of a province-wide engagement with all members. An external consulting firm was secured to help guide, plan, and implement a consultation process to achieve the following:

- Listen to members, and ensure their concerns are heard.
- Validate and better understand the key issues facing both family physicians and specialists related to primary care.
- Hear about members' priorities, ideas, and supports needed to stabilize practices.
- Report back to members on what was heard and how input will be considered and actioned.

Commitment to members

Doctors of BC committed to listen to members, and to use the feedback to:

- Take visible and urgent action, and advocate strongly with government for tangible short- and-long term solutions and changes to support longitudinal family practice and primary care.
- Shift our own organizational approaches, and inform advocacy at the Physician Master Agreement table.
- Empower those who represent members' interests and perspectives at the collaborative tables.

Who did we need to hear from?

All members: family physicians and specialists from across BC, who are all experiencing the impacts of the primary care crisis in their practices and in the system.

We also needed to hear from recent Family Practice graduates and new-to-practice family physicians as future doctors working in family practices and primary care.

Who was consulted or involved in the design and support of this engagement?

- Doctors of BC Board and physician Leaders, senior leadership team, strategy teams, and staff
- GPSC Caucus members
- BC Family Doctors
- BC College of Family Physicians
- Resident Doctors of BC

Who are the stakeholders that will be engaged in the outcome of this engagement as we collaborate for potential solutions?

- Doctors of BC Board and physician Leaders, senior leadership team, strategy teams, and staff
- GPSC Caucus members, committees, working groups
- Divisions of Family Practice
- Resident Doctors of BC
- BC Ministry of Health
- Regional and First Nation Health Authorities
- External groups involved in addressing or impacted by the primary care crisis
  - BC College of Family Physicians
  - BC Family Doctors
- Partner organizations/allied health care organizations

Engagement approach: Consult and involve

The external engagement consultants recommended the member engagement effort follow the IAP2 Public Participation process as a leading engagement practice. This internationally acclaimed process is field-tested and well suited to efforts designed for large target groups. The engagement process was designed to include IAP2's Engagement Spectrum (see below) and focused primarily on the **Inform, Consult and Involve** levels with associated stakeholder commitments.

IAP2 Spectrum of Public Participation

IAP2's Spectrum of Public Participation was designed to assist with the selection of the level of participation that defines the public's role in any public participation process. The Spectrum is used internationally, and it is found in public participation plans around the world.

INCREASING IMPACT ON THE DECISION

PUBLIC PARTICIPATION	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
PROMISE TO THE PUBLIC	**To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.**	**To obtain public feedback on analysis, alternatives and/or decisions.**	**To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.**	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision making in the hands of the public.
	We will keep you informed.	**We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.**	**We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.**	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.

Validation of the engagement approach: Representative Assembly (RA)

The proposed engagement approach was shared with members of the Doctors of BC Representative Assembly at their May 27, 2022, meeting for feedback on its focus, questions, and overall process. The RA includes 108 voting members and diverse representation of family physicians and specialists practicing in rural and urban communities in BC, and at all stages of their medical careers.

RA members generally supported the proposed regional virtual sessions accompanied by 24/7 access to an online platform. They expressed concerns about re-engaging members so soon after a previous effort (physician burdens) and emphasized the need to move from 'more talking' to 'swift action' in the effort.
See full feedback here.

Engagement process supports

Supports were brought together to increase member opportunities to participate and be heard:

Internal resources including Doctors of BC staff to support discussion sessions.

Strategic communications supports to share engagement-related information in a timely, accessible and transparent manner.

Reporting to members through regular updates with highlights of what we were hearing at virtual regional discussion sessions, with a commitment to consolidating a final summary report.

Evaluation: Session questionnaires and debriefs for participants and the project team to share aspects of the engagement sessions that worked well, and to contribute ideas to adjust and improve the engagement process as we moved forward.

Background documents for members to optionally read prior to engaging:

How Doctors of BC is Supporting Primary Care (106 KB) (pdf)

5 Things to Know About PMA/Negotiations (87.7 KB) (pdf)

Burdens of Practice (101 KB) (pdf)

Input from specialists (101 KB) (pdf)

Overview of member consultation approaches: 3 ways to engage

Nine facilitated virtual sessions – June 22 to July 14, 2022

Detailed themes from virtual and online sessions follow on page 18.

Virtual discussion sessions were supported by Doctors of BC physician Board members and senior leaders who welcomed participants and provided context for the engagement approach and desired outcomes, and actively listened to member input shared during breakout sessions.

Members were asked:

- *What short term actions could help keep family physicians in longitudinal care?*
- *What are some ways we can better demonstrate the value of the work of family physicians?*
- *What characteristics of any potential new payment model would support you in the way you would like to practice, as well as ultimately support the system improvements needed?*
- *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?*
- *As we consider stabilization of practices, what resources would help you address burdens?*
- *Help to prioritize resources to best reflect your current need.*

Value

At all nine facilitated sessions, family physicians and specialist consultants shared great concern about the perceived dwindling value of longitudinal primary care.

Members felt that intentional efforts to validate, reposition, and appropriately compensate the work of Family Physicians (FPs) – with demonstrated leadership from Doctors of BC – will better sustain and improve longitudinal family practice.

Members emphasized 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).

Many feel that family doctors should be referred to as specialists in family medicine. Members also said they would like to be identified as a 'physician' rather than a 'provider,' to respect value and role, and for clarity.

Members highlighted myriad burdens and constraints that contribute to the many challenges of practicing primary care in BC, and physician burnout.

Discussions focused on examples of inadequate, inequitable compensation and pay disparity for physicians delivering longitudinal primary care. Fee levels are not reflective of the current complexity of care, inflation, and ever-increasing costs of overhead and maintaining a practice. Members expressed concerns about mounting administrative tasks, paperwork, human resource constraints, outdated technology, and unrealistic practice standards and expectations.

Members articulated short-term priorities to stabilize primary care at the practice level.

Members agreed on the urgent need for action including additional remuneration, funding, and supports, as well as strategies and resources to drastically and strategically reduce current workloads, administrative tasks, and escalating costs associated with operating longitudinal family practices. Identified resources included financial, personnel, and healthcare system-wide supports, and increased access to team-based care.

Members also considered what could be added to the discussions underway with government about compensation models for longitudinal family practice and criteria for any emerging payment model – and what compensation elements could be used to stabilize the profession.

Flexible model preferences – fee for service (FFS), alternative payments, contracts – are all respected as options for individual FPs' preferences, although it is clear each has constraints and needed improvements. Existing options of Ministry contracts or fee for service are not sufficient to meet practice needs or retain FPs.

Many members do not want to move away from FFS, and would prefer to have the option to continue with a stronger, improved FFS model.

Many FPs are unsure about pursuing current contracts with concerns that include balancing patient volumes with workflow, time, and compensation constraints, and the role of the health authorities in managing contracts.

Members also want increased transparency in contract negotiations and results of service delivery models that have been tested. Changes need to be drafted through true collaboration with the Ministry of Health, rather than top-down.

Online “Have Your Say” platform – June 20 to July 15, 2022

Members provided perspectives, concerns and ideas, and asked questions on the online Doctors of BC Have Your Say platform.

Discussion forums focused on three topics:

- *Value and Compensation*
- *Addressing Cumulative Burdens*
- *Specialist Considerations*

Many themes heard from members during the virtual discussion sessions were echoed on the online platform. Participants supported the need for family physicians to be valued for their role in longitudinal care, and adequately compensated for it.

Physicians agreed with the urgent need to address a number of burdens and areas – including physician supports, administrative supports, technology, and practice requirements. There were some differences in the sub-themes from the virtual facilitated sessions. Additional compensation feedback was also captured from the online comments, along with specialist considerations.

A number of comments suggested that there is a need to bring patient-centered care back into focus —a number of process issues exist because patient needs are not put first.

The online platform captured additional perspectives from specialists about the impacts of the primary care crisis on their patients and work.

Specialists respect the value and importance of longitudinal care, and empathize with the challenges that FPs face. They agree with the urgent need for increased remuneration for FPs and support for rising overhead costs (which they also experience).

Specialists and FPs noted that their practices and patients would benefit from improved collaboration, communication, processes, and referrals between them, and stressed the need for a centralized EMR/EHR information sharing system across care settings.

- Member input from the online platform are rolled up together with themes from the virtual discussion session themes, starting on page 18.
- Specialist perspectives follow on page 28.

Family Practice graduates and new-to-practice (NTP) physician virtual discussion – July 20, 2022

Participants of this session shared their unique perspectives and thoughts on primary care and entering longitudinal family practice.

Supported by both a Doctors of BC board member and senior leadership team member, participants were asked:

- *What do you feel are the key challenges and barriers to working in longitudinal family practice?*
- *What big picture solutions, resources, and supports need to be in place for you to consider committing to a community longitudinal family practice in your future career plans?*
- *Knowing that a model of payment should ideally be simple, easy to access, equitable with other offerings, and allow for clinical and personal autonomy: What other specific features would be important to you in how you are paid for community longitudinal family practice?*
- *From your perspective, what key elements of personal, practice, or system supports need to be in place to support NTP physicians providing locum coverage to established FPs?*

Residents had several concerns about entering longitudinal family practice.

New-to-practice physicians told us they want to achieve work/life balance, avoid burnout, and focus on medicine, rather than administration. They see overworked family physicians in existing practices experiencing increasingly unmanageable workloads, inadequate compensation, unpaid administrative tasks, expensive overhead costs, and complex patient care without adequate support. This does not make longitudinal family practice an attractive or positive choice, and many new graduates are avoiding it.

Residents want flexibility to fully explore practice options in the critical, first five years of practice.

Many recent graduates felt ill-equipped to make clinical and business decisions without more real-world experience. They want to do locum work and experience different community practices and sub-specialities before committing to a longer-term practice situation and longitudinal care.

Residents envisioned elements of an ideal practice in which they would like to work.

New-to-practice physicians are looking for appropriate compensation and autonomy. They want to spend time caring for patients and doing medicine with appropriate supports, rather than managing a clinic. Ideally, they want a manager, or super MOA to run the office, and support for staff to handle administrative tasks. They want a healthy and balanced work life, with the ability to take time off and leave for parenting.

Detailed feedback from this session can be found on page 30.

Burdens: What we heard from members

Themes consolidated from all virtual discussion sessions and online feedback

Burdens

As heard in previous Doctors of BC engagements on physician burdens, members gave examples of a range of burdens that take their time and focus away from patient care, risk practice sustainability, and contribute to physician burnout.

They emphasized some common themes:

- *Increasingly unmanageable workloads leading to poor work-life balance, which translates to many new graduates avoiding longitudinal family practice.*
- *The need to dramatically and strategically reduce the escalating workloads, burdens, and costs associated with operating family practices.*
- *The nature of family practice as a catchall for countless issues or tasks that fall through the gaps in the health care system. Many 'asks' of a family physician's time beyond their traditional role adds a burden of responsibility and time on the doctor and/or their staff, and negatively impacts their ability to see more patients, and complete their workday in a reasonable amount of time.*

Members emphasized a number of burdens they commonly face, and proposed ideas and solutions for reducing some burdens, which are rolled up on the pages that follow. Several common themes emerged:

Forms, administrative tasks, and processes

Physicians are facing increasing volumes of time-intensive, complex forms and requests; unnecessary and/or redundant levels of paperwork; and time-consuming processes for insurance claims, sick notes, re-referrals, etc.

The complexity of billing codes and fees

Sorting through and taking advantage of billing codes adds a cognitive and time burden to family physicians.

Poor access to necessary services and supports for patients

Many asks of FPs are beyond their training/ability, time and/or capacity to manage, and ability to arrange/access, including mental health supports, appropriate allied health supports, diagnostic imaging, and lab services.

Lack of locum access and availability

It is challenging for FPs to take a break for illness, family needs and emergencies, vacation, professional development, and/or maternity/paternity leave. It was noted that many women leave practices in the first five years.

Specialist collaboration and follow-up

Additional work and time is required by family physicians and their staff to support patient needs related to specialist care, manage referrals and re-referrals, communicate with patients, and follow up on investigations.

Training and compliance

The training burden and numerous requirements needed for an FP and practice to remain compliant, such as privacy, HR development needs, IT systems, managing conflict, etc., diverts time, resources, and capacity from medical care.

Inefficient technology/EMRs, siloed patient information

Lack of access to information in one place with multiple EMR systems leads to information silos, unnecessary phone calls, manual use of faxes, retyping of information, etc., all of which reduces time for direct patient care.

Virtual care

FPs are experiencing challenges with the integration of virtual care in practice, related policies and systems, and concerns about competitive consumer options.

Practice requirements

Physicians feel that the volume, tone, and content of College requirements, guidelines, and standards imposes unrealistic obligations on them and can decrease their ability to effectively operate and lead to burnout. Additionally, the current licensing process has barriers and is too lengthy.

Solutions: What we heard from members

Themes consolidated from all virtual discussion sessions and online feedback

Compensation

Compensation: Remuneration

Compensate FPs appropriately as the most qualified people to provide longitudinal primary care, and for the work involved, and in ways that increase net income.

- Pay family doctors for the intensity and ongoing commitment of relationship-based care.
- Pay family doctors for the time needed for patient care (both direct and indirect), its increased complexity and investigations, and related administrative tasks, paperwork, and EMRs.
- Consider incentivizing years of service to keep physicians in practice.
- Give a time-of-service retention bonus to encourage mid-stage FPs to stay in practice, and until a true age of retirement.

Compensation: Pay equity

Compensate family physicians fairly and equitably among themselves and with their peers. Members commonly agree that compensation inequity exists across similarly-trained physicians and the spectrum of FP services (e.g., family practice, hospitalists, UPCCs, virtual care), and between genders.

- Provide fair compensation that is competitive with other family physicians.
- Compensate appropriately (and higher) for longitudinal family practice work in relation to episodic care or time-based hospitalist work. Incentivize continuity of care.
- Acknowledge the differentiation between FPs and specialists and comparative pay relativity in terms of workload and value of strong primary care to patients and the system.

Compensation: Indirect, unpaid care-related work

Pay FPs for required additional time to complete care-related work for patients, such as time spent working after hours to chart, process labs, fill out paperwork, and be available for call. No more unpaid work.

- Many members see time-modifiers as a way to better recognize and support the uncompensated time.
- Consider the idea of creating a simple billing code/flat half-day or daily fee (for each different type of physician) to acknowledge unpaid work, and provide overhead relief.
- Eliminate mandatory 24/7 call requirements —discontinue or, at the very least, compensate adequately and equitably those who opt to provide it; including family physicians who cover community, hospital, long term care facilities, and maternity care.
- Consider using 811 to screen after hours calls and, if non-urgent, have the patient book the next available appointment.

Compensation: Infrastructure and overhead supports for family practices

Address the urgent need for sustainable financial supports for rising overhead and operating costs, including for example: escalating lease costs, staff wages, technology, and inflation. Significant and rising overhead costs in both urban and rural areas have become a barrier to the sustainability of practices.

- Provide overhead support as is done for nurse practitioners, and to clinic operators directly.
- Work with the Ministry, health authorities, and/or municipalities for subsidized leases for FPs/physician-operated clinics, especially in new building developments.
- Negotiate reduced property tax for clinics on triple net lease, recognizing that FPs are not commercial businesses that can increase fees/income to compensate for increasing costs.
- Reimburse for overhead costs associated with:
  - EMRs and related fees. (EHRs in hospitals are funded by MOH.)
  - Increasing technology requirement (costs of which are unsustainable), including telehealth/virtual care (e.g., online scheduling/patient portals, secure patient messaging, high speed internet access, routers, firewalls/security, hardware/software, monthly subscription fees for equipment maintenance, e-fax, phone lines).
  - Voice dictation for clinics to reduce documentation burdens. (Funded in hospitals as part of the workflow.)
  - Medical office supplies, sharps containers.
- Support costs for competitive MOA salaries, cost of living increases, additional benefit and pension options for doctors and their MOAs.

Compensation: Diversity of payment models and considerations

Offer a suite of compensation options that support the unique needs of individual physicians, stages and types of practice, diversity of communities and geographic locations, and availability of local services. Increase with annual inflation rates.

- Improve current payment modalities to offer more flexibility and choice to better reflect varied practices, and include support for overhead.
  - Ensure models of payment are equitable for the different needs of FPs, including whether they are clinic owners or associates, or work in multiple practice settings, or with practice sharing arrangements.
  - Better align payment models with the various roles and functions of a clinic, as FPs practice in a variety of ways (full time, part-time, etc.).
  - Offer part-time options for FPs with families or to take maternity leave, to incentivize a career choice in family medicine.
  - Include options specific for the unique needs of rural FPs (who also take time out of their practice to work in hospitals) to consider how remote and rural practices and doctors operate locally and within the context of a larger system.

- Contract options should protect clinical and business autonomy for those who want it. Trust and respect physicians' professionalism.
  - A fee for service (FFS) model with time modifiers would be beneficial to also provide autonomy and flexibility. (See more feedback on FFS below.)
  - Consider a blended model of salary and FFS and time modifiers, and incentives rewarding good/hard work.
  - Increasing the Community Longitudinal Family Physician Payment (CLFP) is an attractive financial option given the commitment and responsibility as longitudinal physician.
- Investigate models in other jurisdictions as well as those with a history in BC including population-based funding and blended models (e.g., Mission, Fort St. John, Langley).
- Do not flow payments through the health authority.
- If capping income through a fixed funding contract, do not cap costs/expenses of running a clinic, as it will never be sustainable.
- Keep no daily maximum for patient volume limit, in consideration of the limited availability of doctors for primary care.
- Models must be simple to sign up for and work under. Current contracts are too long: simplify.
- Members noted that there is no desire to see a BC version of the NHS contract-style model found in the UK, which has issues.
- Recognize value for preventative care in the family medicine compensation model.

Compensation and payment model criteria: Additional online feedback:

On the Have Your Say online platform, members discussed compensation model criteria recently developed by Doctors of BC and designed to underpin any new and emerging payment model discussion and development with session participants. Participants weighed-in on the suggested criteria of Equity, Value, Availability, Autonomy, and Simplicity. The majority agreed with the list, and some suggested tweaks including:

- **Equity**—pay for longitudinal care should actually be higher than that for episodic care, aligned with the value provided to patients and the system and workload and costs required to maintain a family practice, and when compared to other physicians.
- **Value**—there should be no unpaid work.
- **Simplicit**y—proving complexity by creating a long list of diagnostic codes defeats the purpose of simplicity.

There was also the suggestion of an additional criteria:

- **Safety net support**— for physicians who are off for medical reasons, parental leave, burnout, vacation, etc.

Some expressed concerns about the criteria, primarily for the following reasons:

- The needs of FPs who want to provide clinical care but not be involved in running a business, and FPs that desire both clinical and business autonomy, need to be considered.
- Desire to retain Fee for Service.

Compensation: Fees and billing codes

Urgently update, simplify, and increase fees to align with the current context and realities of care, and for the diversity and complexity of care, and time needed for patients. Members commonly agree that current fee levels are at minimum, "a decade behind current day cost levels. Existing limits on current billing are a concern. Additionally, the current FFS model encourages short and often unsatisfactory visits for patients.

Fees / rates

A significant number of participants wanted to see improvements in Fee for Service rather than an entirely new payment model. Suggestions included:

- Improve overall rates, and appropriate payment for time.
- Add time modifiers/FFS extenders as a potential solution, and to address complex/ multiple issue visits.
- Simplify fees and incentives.
  - Many could be consolidated into a handful of procedure visits and paid at the same rate.
- Expand remuneration, fee codes, and criteria for complexity. For example:
  - Mental health consultations for FPs comfortable providing that care.
  - Counselling/cognitive behaviour therapy.
  - Complicated procedures.
  - Comprehensive scope of practice (e.g., office-based maternity care, hospital care).
  - Completion of some of the more complex forms such as CPP forms.
  - Completion of a Death Certificate and other publicly-required forms for which FPs are legally responsible.
  - Rapid access availability and for "no-shows".
- Preserve telehealth fee codes to help maintain patient access, and flexibility in work.
- Pay for non-direct care such as prescription refills by fax, review of relevant labs, specialist referrals, follow-up tasks from specialist consult reports.
- Pay full amounts for each issue/procedure done in a visit, not just half or less. Eliminate the 50% "discount" for additional services.
- Reconsider the 10-15 minute visit guideline to accommodate longer appointments for complex needs, and related administrative time – charting and labs.

Team based care compensation

Compensation models need to support team-based care in practice.

- Pay physicians for the time it takes to train and manage a cohesive team of allied health care providers (some whom have no primary care training), and for maintaining clinical (MRP) responsibility for those providers.
- With team-based care incentives, don't penalize those who provide exceptional care to their patients as solo practitioners.

New financial supports

- Do not attach unrealistic expectations, workload, or responsibilities to new financial resources. Taking on new patients is not realistic nor enticing due to already unmanageable patient panels and overburdened staff.

Physician supports

Locum coverage

Urgently address the shortage of practice coverage resources and the challenges associated with cost, scheduling, and availability, to attract and retain locum FPs – a significant contributor to the current crisis, patient access challenges, and physician burnout. Robust locum resources and supports (including better support for rural communities) are part of the solution to sustaining longitudinal family practice and continuous patient access to care.

- Increase short- and long-term locum supports for planned and emergency coverage, to support the urgent need of FPs to take time off for illness, family needs, vacation, professional development, and/or maternity/paternity leave, and to retain FPs.
- Fund and establish a robust, centralized, easily-accessible, and coordinated provincial locum pool.
  - Create a central repository for all locum opportunities instead of multiple websites and word of mouth.
  - A funded locum program like the Rural Locum Program would be ideal.
- Increase the number of weeks of locum coverage that can be accessed based on years of service.
- Simplify and streamline systems to attract, license, and secure new locum physicians. Current process requirements are barriers to effective locum recruitment.
- Make locum work attractive and fairly remunerate and support locums:
  - Provide a minimum daily fee/guaranteed daily rate, or sessional rate, with built-in administration/overhead costs supported separately.
  - Compensate for extra appointment time for new patients and those who are not part of the regular panel, time to navigate the EMR, indirect care, and being on-call.
  - Support locum challenges (e.g., child care, uncompensated travel time, accommodation).
  - Consider FFS with time modifiers to provide locums the flexibility to work at different clinics.
- Ensure locum contracts support the needs of both the locum and host physician.
- Provide transparency around pay: the compensation split, how much (minimum), when paid, and clinic follow-up of payment.
- Increase flexibility and opportunities for international medical graduates (IMGs) and Return of Service to do locums instead of fixed longitudinal care.
- Provide better support for graduating/new to practice FPs to explore and be comfortable with locum opportunities.
  - Increase focused resources for smooth transitions into new communities and practice: appropriate orientation, “tips and tricks,” access to mentors, overlap in new communities.

Family Physician recruitment

Address challenges around recruiting new and/or additional physicians to BC.

- Focus on solving issues for the retention of current FPs; recruitment will flow from that.
- Simplify and streamline systems to attract new physicians, remove barriers, and add new resources to better support rural and remote communities.
- Fast-track / reduce licensing barriers for qualified physicians from other countries, allowing them to practice without as many hurdles.
- Improve the practice environment and opportunities to attract and retain new graduates to longitudinal primary care.
- Incentivize new grads including loan forgiveness, better pay, and more ability to have time off.

Administrative supports

Reduce or streamline the administrative workload of an FP and practice staff to improve clinic operational efficiencies and allow physicians to maximize direct patient care. Simplify redundant processes and paperwork, including referrals, re-referrals, billing, and forms; and support and fund additional resources for office staffing, business supports, and technology needs.

Forms

- Simplify, standardize, and centralize forms for labs/images/referrals instead of different forms for each clinic, specialist, health authority, imaging, etc.
  - Adopt standard conventions for most forms.
  - Consider having family doctors/designated group approve forms and content for practicality and appropriateness.
  - Make all forms available through EMRs, and have EMR vendors convert and integrate before implementing, instead of adding the task and cost to individual FPs and practices.
- Reduce or eliminate paperwork and forms (often offloaded to family doctors) such as insurance requirements, functional assessments, disability forms, sick notes, and pharmacist forms. Remove the burden of responsibility with significant time impacts on FPs to:
  - Produce accurate information for legally binding documents.
  - Meet an organization's legal or administrative requirements for physician sign off .
  - Determine whether patient qualifies for services/supports.
  - Educate patients about uninsured services in BC.

Further suggestions include:

- Maintain the elimination of sick notes, as is done for COVID.
- Improve and harmonize provincial and federal disability forms.
- Create a policy statement that FPs can use to respond to employers/insurance companies/third parties who demand unpaid FP work.
  - Whoever wants forms should agree to pay the FP.

- Overall, stop transferring responsibility for all forms to FPs. Most could be filled out by someone else (a company, a nurse, a patient).
  - Explore another mechanism for completion of insurance forms, such as a comprehensive occupational health service in BC to address insurance issues. Or have insurance companies' own physicians do medical assessments.
  - Support nurses to complete forms within their scope.
  - Have Occupational Therapists complete the functional assessment form.
- Remove FPs as gatekeepers for disability assistance items such as dressing supplies, electric scooters, compression stockings, diet supplements, etc.

- Revisit all current required forms and communications systems with pharmacists.
- Pay physicians for completion of special authority (SA) forms, or shift to pharmacists, or eliminate SA forms for all but the most expensive medications.
  - Speed up processing for SA forms (3 months+) to ensure patients medications are covered, and to eliminate extra time for FPs to follow up.
- Address WorkSafeBC claim approval issues and delays, to ensure patients get appropriate and timely supports for their work-related injury, and so FPs don't have to chase WorkSafeBC for payment.

Office staffing

- Delegate tasks, operations, and office management work to others who are trained, experienced, and better suited to manage administrative work.
  - Fund, attract, train, and retain additional office/staff supports to manage a variety of administrative and daily tasks. (Note that rural practices may have reduced access to required additional supports.)
  - Consider a practice coordinator role to manage tasks and logistics of care.
  - Increase HR supports to effectively maintain staff, and to plan for better pay and benefit options, so that FPs can compete with other employers.
  - Consider a Physician Assistant role to help with administrative flow.
  - Dedicate resources for panel management to relieve FPs from time-consuming, data-focused work.
- Stabilize and fund an enhanced MOA role and functions (or super MOA), through advanced training, increased pay and benefits to create career opportunities that result in increased patient supports, clinic team connection, loyalty and longevity.
  - Elevate existing MOA roles to assist FPs with more complex and time-consuming tasks and duties. Functions could be multi-faceted and involve patient frontline duties, including assisting FPs with more complex and time-consuming tasks and duties, taking patient histories, billing, scribing, and other documentation.
  - FPs should be able to delegate tasks and duties to MOA staff, and bill for them.
  - Create a level playing field with health authority offerings to MOAs so that staffing levels stay consistent and effective.
  - Address the issue of UPCCs draining local area talent pools including MOAs.

Business supports

- Provide business supports to help with business licensing, incorporation, back-office processes.
  - Explore possibility of having a hub and spoke model or a coordinator team that could circulate through clinics helping them modernize.
- Address the training burden and numerous requirements needed for an FP and practice to remain compliant such as privacy, HR development needs, IT systems, managing conflict, etc.

Technology

Urgently invest in and upgrade coordinated, centralized EMR technology across BC to support patient care, minimize duplication and silos of information, maximize user efficiency, and reduce administrative burden. Move away from antiquated and inefficient technology like faxes.

- Fund and develop a provincial (or regional), accessible, easy to use EMR system.
- Coordinate EMR interoperability to enhance communication and quality of care — including to integrate with hospital EHR systems, labs, imaging, and outpatient systems.
- Streamline, update, and enhance EMR functionality (e.g., easier search, e-Prescribing, instant messaging, ordering of labs and imaging, and a summary for each patient with all relevant information).
- Integrate Pathways into EMRs.
- Improve EMR deficiencies and gaps with other systems (e.g., LifeLabs doesn't indicate lab results are still pending, multiple versions of lab results, etc.).
- Coordinate a system for diagnostic imaging results from non-health authority providers which can go missing due to multiple delivery methods.
- Secure, centralize, and fund skilled support for IT and EMR operations (instead of having FPs take time and focus away from patient care) to train and manage IT/business/operations systems.
- Address inequitable technology costs between FPs across health regions.
- Support and improve access to patient data standardization in order to support outcome measurement.

Patient care supports

Team-based care

Broaden team-based care to better support patients' complex needs and increasing community needs, and reduce burdens on family physicians.

- Revisit the approach of team-based care to ensure effective implementation, and to provide sufficient and better diversified skillsets and supports to family practices.
- Further develop, fund, and expand Allied Health resources including nurse practitioners, registered nurses, mental health professionals, and prompt access to social workers and counsellors.
- Diversify care teams to include home care supports, occupational therapists, physiotherapists, therapists, counsellors, dietitians, and others who are regularly required to meet patient needs, and who can prevent/reduce additional FP visits.
- Ensure that every member of the team is valued and recognized appropriately for their skills and contributions—including family physicians.
- Allow FPs to decide which team members would best fit the needs of patients in their clinic. This allows autonomy in practice and improved practice efficiency and capacity.
- Clarify and communicate the role/relationship of nurse practitioners as a valued member of the team, rather than equivalent or a replacement for family physicians.
- Have nurse navigators as part of the support system for high health care users.

Physician networks

- Organize clinical physician networks with supports - such as neighbourhood networks - to provide out of hours coverage, reduce isolation and increase connections that can help support the efficiency of patient care.
- Consider shared care models, including a shared MRP, as a realistic alternative to having a singular entity carry the burden.
- Consider having patients attached to a clinic in order to enable easier cross-coverage of patients during vacation or illness.

Specialized supports and services

- Improve access to specialized patient supports.
- Urgently fund and expand access to mental health and substance use services and supports, which is a crisis in itself. Many family physicians don't have training or cannot adequately support these patients.
- Increase patient access to critical resources including equipment, lab services, diagnostic imaging, mental health, and substance abuse supports for the provision of timely and quality care. Access is very challenging (post pandemic), delaying care.

Virtual care

Consider a range of views about the integration of virtual care into longitudinal care practice. FPs and specialists value being able to provide some patient care virtually. There are concerns, however, about the exclusive use of virtual care by episodic care practices, which some suggest should be disincentivized by compensating less for virtual appointments in these settings.

- Address rising issues, concerns, and tensions that have developed between longitudinal FPs and episodic corporate providers of virtual care, and the climate of competition for compensation, financial supports, personnel, and other resources; as well as considerations about appropriate quality care.
- Explore ways to seamlessly integrate virtual care/telehealth into primary care practices.
- Establish appropriate levels of care, and fair and effective processes (wait times, referrals, etc.).

Practice requirements

Advocate for the College to review guidelines and standards—with an aim to improve the volume, tone, and content — and better meet the reality of physicians working in current complex primary care environments.

- Acknowledge that College expectations need to have more meaningful consideration of the impacts on physicians and their ability to control system challenges. Expectations on FPs should be realistic and respectful — not increase burnout or ability to effectively operate, nor impose onerous obligations or expenses on physicians that compromise patient access to quality care.
- Identify guidelines and standards that are realistic and measurable, resulting in mutually agreed-upon expectations appropriate for individual physicians to deliver. Consider having Doctors of BC be part of any consultation on how to implement any changes.
- The current licensing process has barriers and complications and is too lengthy — a six-month to two-year wait. Explore why other province's colleges are more effective.
- Address lengthy waits for processing incorporation and business license applications.

Governance/system

Address challenges related to Urgent and Primary Care Centres (UPCCs)— including ongoing dysfunction and competition emerging from relationships with community-based primary care providers, compensation discrepancies, governance and roles in primary care networks, and minimal patient attachment.

- Address compensation discrepancies and inequities with community practices that also lead to recruiting challenges for locums and longitudinal practices.
- Consider providing more support for family physician-run clinics instead of UPCCs.

Data-driven practice

Improve access to and use of data to support performance, measure outcomes, and validate impact. Consider partnering with post-secondary institutions to research and develop data collection and outcome measurement strategies.

Specialist considerations

Patient care impacts:

Specialists noted a number of impacts of the primary care crisis on their patients and work.

- Too many unattached patients are using the Emergency Department inappropriately because they can't get care in the community contributing to unsustainable overload of EDs, and erosion of timely emergency care.
- Patients are not getting medications renewed, affecting other specialities.
- Patients are not getting post-hospital/discharge follow-up for persistent/medically complex issues.
- Patients are readmitted multiple times to acute care because of poor chronic disease management.
- Hospitals cannot provide longitudinal care to admitted elderly patients who are waiting for care in the community: a key cause of bed block.
- There are concerns that patients are being sent to emergency rooms to get faster access to specialists.
- Some specialists pick up some primary care duties to ensure patients are able to continue with their treatments, and feel obliged to help with some medical problems. This can be distressing to specialists who are concerned about practice medicine outside their area of expertise.
- The volume of referrals from consumer telehealth providers has climbed dramatically and with this, the quality of referrals has fallen.
- Some suggestions include:
  - Reward chronic, complex care to keep those patients out of the hospital as much as possible.
  - Have specialists more accessible on a timely basis.

Physician collaboration: improvements

Specialist and family physicians agree on the need to support and lead efforts to evolve and establish more mutually respectful relationships between them, clarify roles and processes, and increase communication and collaboration to better meet the needs of patients and increase morale.

- Improve communication and processes between specialists and family physicians (both directions).
- Urgently address electronic sharing of patient information (EMR/EHR). There is opportunity with the introduction of EHRs to hospitals. Eliminate faxes, manual, and inefficient processes.
- Have specialists be responsible for follow-up of specific tests ordered, rather than offloading the follow-up on recommended tests they have ordered or having FPs check/interpret results.
- Have specialists communicate directly with patients on their wait list, including to notify them of their appointment times. This can add a significant time burden to MOAs in FP practices.
- Encourage specialists to consult with the family physician before unilaterally discharging a patient from their care to the FP when the patient's condition warrants continued specialty involvement.

- Overhaul the referral system to reduce burdens, added costs, and inefficiencies for physicians, the system, and patients.
  - Develop a centralized geographic referral system.
  - Use technology to ensure transparency of actual wait times and what specialists will manage.
  - Establish clear and appropriate guidelines around referrals to help advance appropriate care, reduce wait times, and to simplify practice workflows (which will also reduce the time it takes for MOAs to manage referrals).
  - Confirm receipt of a referral request with the FP.
  - Redevelop the 6-month re-referral process.
  - Eliminate the family physician as the gatekeeper for re-referral forms/letters to a specialist consultant who is providing continuing care but wants to bill a complete consult. This creates work, an administrative burden, and overhead costs for family physicians and staff to process - without improved patients access to consultants.
  - Encourage specialists to accept a no charge referral instead of requiring a new letter to see the patient again in follow up.
  - Eliminate the need for an updated referral for specialist to see patient for chronic routine care.
  - Consider having a set of diagnostic codes that define conditions requiring longer-term specialist care or monitoring (e.g., glaucoma).
  - Recognize that patients with complex chronic specialist-followed conditions fall through the cracks. Those without FPs should not be visiting walk-ins for re-referrals, and should be prioritized for attachment to an FP.
  - Universalize referral forms as much as possible.

New-to-practice physicians: Discussion session feedback

Concerns about entering longitudinal family practice

- Insufficient experience to commit to a practice out of the starting gate.
- Observations of burnt-out preceptors and experiences in poorly managed practices.
- Inadequate and inequitable compensation for the work done in longitudinal family practice, and in comparison to other offerings and that of nurse practitioners.
- The current fee structure, which does not account for complexity of care.
- The real burden of paperwork and working long unpaid hours.
- Expensive overhead costs: having to work more just to keep up with rising overhead costs is not viable in the long-term.
- Lack of coverage for vacations or parental leave. Some have observed colleagues having to close their practice when starting a family due to not being able to find coverage.
- Lack of patient resources, including a lack of mental health supports/access to psychiatry for patients and team-based care for ongoing supports.
- Specialists pushing tasks onto primary care.
- Pressure to take on family and friends as patients with no system capacity to do so.
- Unrealistic expectations of the profession and the College: to be available 24/7 to patients, in addition to non-clinical costs for membership fees, licensing, etc.

Perspectives on payment models

- Like all physicians, early career physicians want a model of payment that is simple and easy to access, that has equitable remuneration with other similarly trained physicians and offerings, and allows for clinical and personal autonomy.
- Alternative payment models are attractive to new-to-practice physicians as they allow for more flexibility to try different options.
- Combining options of new-to-practice contracts with locum opportunities (e.g., a couple of days per week with different exposures might be enticing).
- Provide contract support to help new to practice FPs: what to consider and avoid in contracts.

Transitioning to a practice

- Work with UBC to better plan for and meet transition needs to practice.
- Have strong, intentional clinical mentorship available in early practice from family physicians already in practice, to guide how different practices are managed, avoid issues, etc.
- Make a clear connection to Doctors of BC programs and services that support mentorship.
- Consider organizing clinics to have new to practice FPs try a practice for a week.
- Provide business mentorship.

Elements of an ideal practice setting

- Appropriate compensation.
- Ability to manage patients and medicine, rather than a clinic.
- Access to locum supports for time off/vacation and parental leaves.
- Autonomy: the ability to determine what the practice will look like, dictate size and characteristics of patient panels, set the schedule, and take leave/vacation when needed.
- Realistic attachment expectations: appropriate-sized panels with complexity accounted for.
- A well-run, well-managed practice with a manager or funded super MOA.
- Resources to support and train staff to manage paperwork and other administrative duties/tasks.
- Good access to patient supports, including specialty care and team-based supports with allied health funded by government.
- Full orientation upon joining a practice.
- Being respected by specialist colleagues.
- A centralized distribution system for medical supplies for routine services, (e.g., pap test supplies, flu shots, etc., similar to what was coordinated during COVID for PPE distribution).

Participating IMGs and those completing a Return of Service contract noted that having to commit to a clinic without knowing enough about it and having little power/choice to negotiate is daunting when compared to other Canadian colleagues. Most would like more flexibility in the first five years. They discussed Ontario's five-year Return of Service model with its additional flexibility, as vastly preferred over BC's two-year approach.

Residents additionally noted some concerns about New-To-Practice contracts and the incentives announced in Spring 2022, including having to commit to a specific payment model and practice so early, lack of trust in the process, and a sense of possibly being manipulated and skewed towards agreeing to contracts.

Additional feedback reports on this member consultation:

What We Heard #1: Member feedback from the first group of virtual discussion sessions

What We Heard #2: Member feedback from the second group of virtual discussion sessions

What We Heard from New-to-Practice Family Physicians and Family Practice R2 Residents

What We Heard from the Representative Assembly: member engagement planning

Appendix 1: Member participation

Participation overview

9 facilitated virtual discussion sessions

- June 22 to July 14, 2022
- 360 physician members
- 5 health regions— Vancouver Coastal, Fraser, Island, Interior, and Northern Health

1 Virtual facilitated session for recent Family Practice graduates (R2 Residents) and new-to-practice family physicians

- July 20, 2022
- 85 physicians

Doctors of BC online Have Your Say platform with 3 discussion forums and Q and A.

- June 20 to July 15, 2022
- 2500 plus visits
- 317 physicians contributing 714 comments
- 4617 votes on comments

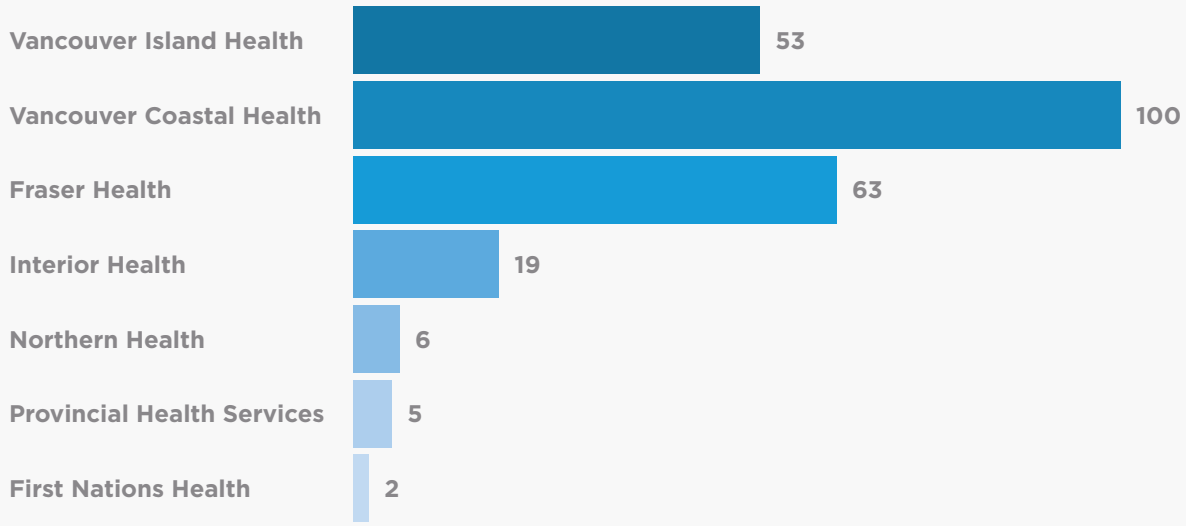
Physician demographics: facilitated virtual discussion sessions

At each of the virtual sessions, participants were asked to complete a poll to allow for better understanding of who was in attendance.

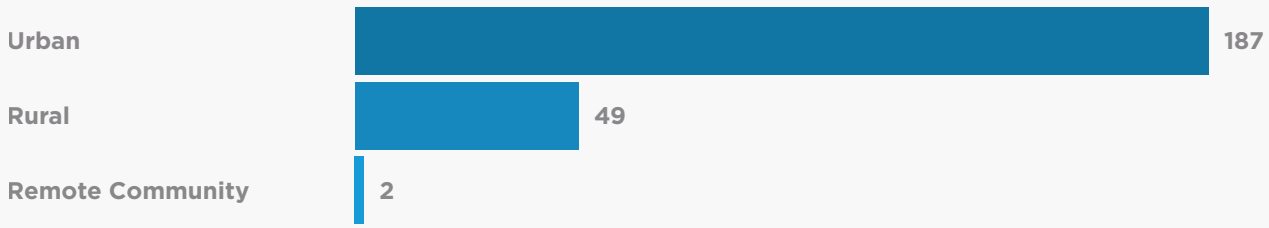
DATE	REGION	ATTENDEES
June 22	Island Health	53
June 23	Vancouver Coastal Health	48
June 27	Interior Health	30
June 28	Northern Health	12
June 29	Fraser Health	45
July 6	Island Health	26
July 7	Vancouver Coastal Health	78
July 13	Fraser Health	41
July 14	Interior Health	27
July 20	Residents and New-to-Practice Physicians	85

Combined June and July virtual session poll responses

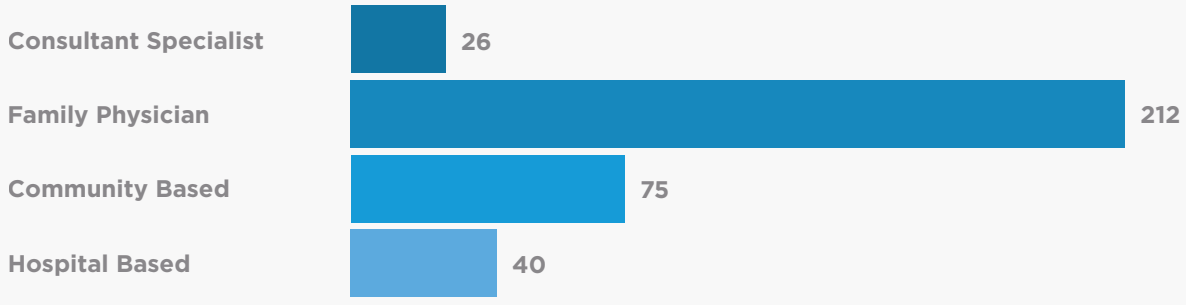
Attendees By Health Authority



By Location

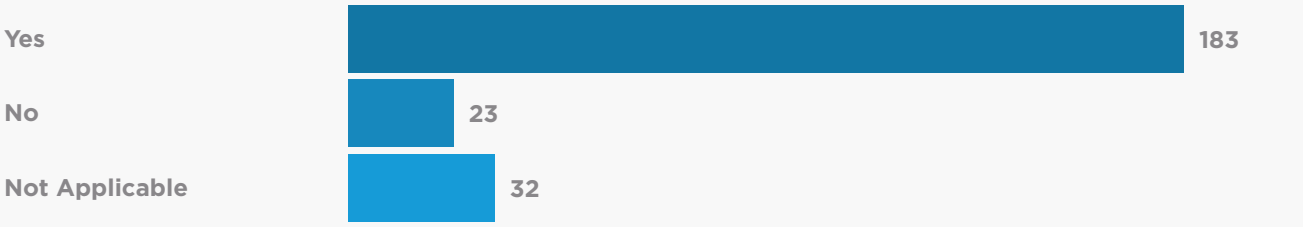


All By Role

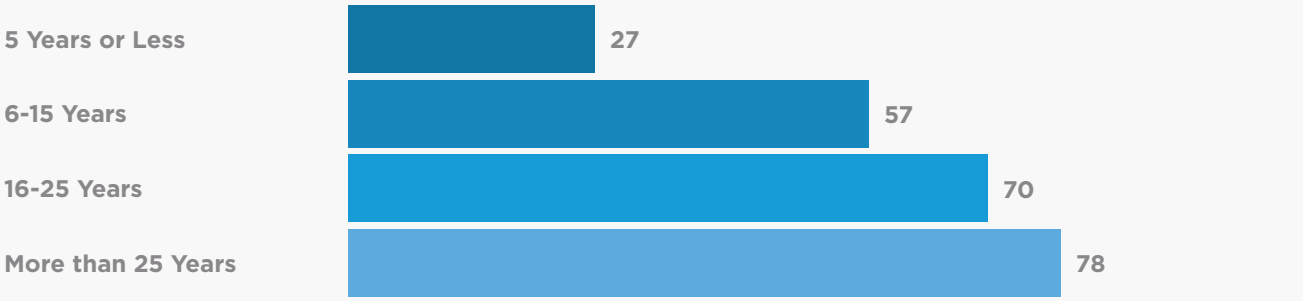


Combined June and July Virtual Session Poll Response data continued...

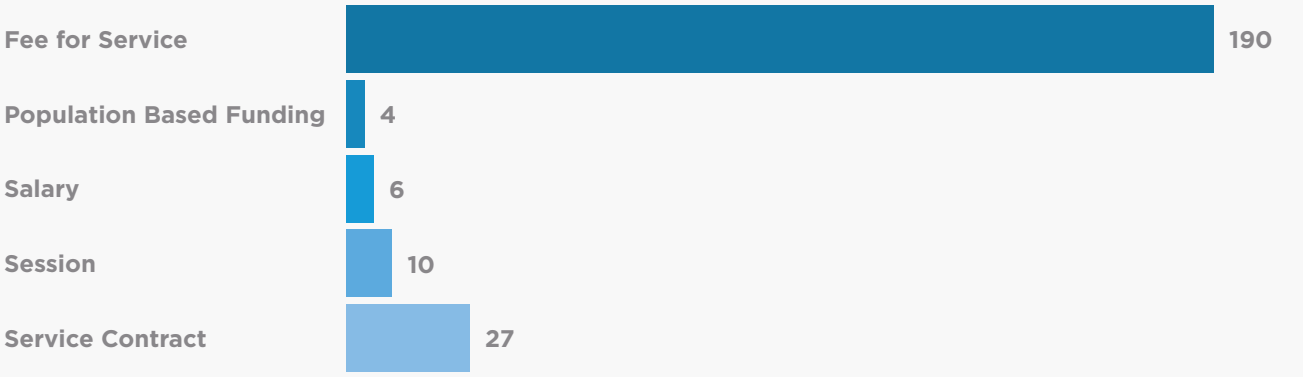
All By Longitudinal Practice



All By Stage in Practice



Payment Model



The following tables outline the demographics of those who accessed the three Have Your Say online platform discussion forums. Upon registration, all forum participants were asked to share the nature of their practice, identify their primary role, share their current career stage, and what Heath Authority they work in.

FORUM 1 – Value and Compensation Have Your Say platform demographics shared:

MY PRACTICE IS	
Facility-based	17
Community-based	106
Both	66

I AM A	
Family physician	173
Specialist	13
Other	3

MY CURRENT CAREER STAGE IS	
Resident	2
In practice for 5 years or less	43
In practice for 6-15 years	54
In practice for 15-25 years	42
In practice for more than 25 years	43
Retired	5

THE PRIMARY LOCATION OF MY PRACTICE IS	
Rural	44
Urban	114
Semi-urban	31

THE PRIMARY HEALTH AUTHORITY IN WHICH I PRACTICE IS	
Fraser Health Authority	27
Interior Health Authority	18
Island Health Authority	22
Northern Health Authority	9
Vancouver Coastal Health Authority	23
No Response	90

FORUM 2 – Addressing Cumulative Burdens poll demographics/data shared:

MY PRACTICE IS (Please select one option only)	
Facility-based	6
Community-based	52
Both	29

I AM A	
Family physician	78
Specialist	8
Other	1

MY CURRENT CAREER STAGE IS	
Resident	2
In practice for 5 years or less	15
In practice for 6-15 years	34
In practice for 15-25 years	19
In practice for more than 25 years	17

THE PRIMARY LOCATION OF MY PRACTICE IS	
Rural	15
Urban	61
Semi-urban	11

THE PRIMARY HEALTH AUTHORITY IN WHICH I PRACTICE IS	
Fraser Health Authority	12
Interior Health Authority	8
Island Health Authority	10
Northern Health Authority	3
Vancouver Coastal Health Authority	9
No Response	45

FORUM 3 – Specialist Considerations poll demographics/data shared:

MY PRACTICE IS (Please select one option only)	
Facility-based	8
Community-based	24
Both	12

I AM A	
Family physician	28
Specialist	16

MY CURRENT CAREER STAGE IS	
In practice for 5 years or less	5
In practice for 6-15 years	20
In practice for 15-25 years	9
In practice for more than 25 years	8
Retired	2

THE PRIMARY LOCATION OF MY PRACTICE IS	
Rural	6
Urban	32
Semi-urban	6

THE PRIMARY HEALTH AUTHORITY IN WHICH I PRACTICE IS	
Fraser Health Authority	6
Interior Health Authority	3
Island Health Authority	3
Northern Health Authority	2
Vancouver Coastal Health Authority	7

Appendix 2: In your words

In your words:

A selection of member comments received through our online Have Your Say platform. Comments from virtual discussion sessions are included in the interim What We Heard Reports here.

Comments on burdens and challenges

My biggest burden is trying to keep my practice going without adequate funds, locums, or acknowledgement. I love my job and my patients (for the most part!), and worry so much about what will happen to them if I become ill or need to retire.

COSTS AND OVERHEAD

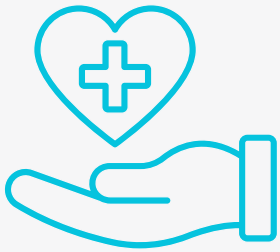
- *The two biggest costs are rent and staff wages. Our lease rates skyrocketed the last time we came for renewal and we have just had to take a bigger loss in personal income to compensate. Despite paying MOAs at the higher end of the pay scale, our office is having staff poached by [the health authority]. Private offices cannot compete with the hospitals in wages and benefits that they provide.*
- *Rent in both urban, semi-urban, semi-rural and rural settings can be prohibitive.*
- *There needs to be compensation to cover the infrastructure of rent, staff and supplies. Why should I be be subsidizing the system. Would you expect a teacher to pay for the cost of the school out of salary?*

FORMS, ADMINISTRATIVE TASKS AND PROCESSES

- *I am bombarded by forms from various organizations (insurance companies, disability, LTC, workplaces, summer camps, road safety BC) who have decided a doctor needs to fill out a form likely with no consultation with a doctor. Almost all of these forms could be filled out by someone else (a nurse, the patient).*
- *So much of what we do in family practice is low value "paperwork"... Why do the people with the most education get to spend the least amount of time with patients?*
- *The volume of paperwork has increased exponentially. I can easily spend 2-3 hours doing paper work a day. All the while getting daily pleas to take on more patients.*

BILLING CODES AND FEES

- *The complicated rules with GPSC incentive billing, or the bagillion MSP fee codes. I have been in practice for 9 years now and still find things I could have been billing that would have increased my income significantly.*
- *Having to work in such a way to get paid changes my motivation for caring for patients (i.e. spend minimum amount of time to access a fee, patient must have certain dx to be considered "complex", etc.) This increases my administrative burden and takes the focus away from being able to take care of my patients.*



PATIENT SERVICES AND SUPPORTS

- *I have nowhere to refer complex mental health patients…Currently half of my patients are mental health. I have patients who are bipolar and have worsening post partum depression and are on waitlists for perinatal mental health until 2023.*
- *Being unable to access the care (special investigations, procedures, and specialists to name a few) in a timely fashion creates moral distress and huge loss of job satisfaction.*
- *Allied Health professionals provide an invaluable service for my patients but so far it is more like a referral service than true team-based care. It is beneficial for the patients but has not resulted in any real benefit for the family physicians and does not lessen the current burdens faced by us.*

LOCUM ACCESS AND AVAILABILITY

- *I recently took my first two weeks off in 15 years, yet I had to work one week of it doing virtual medicine just to cover the lack of no coverage.*
- *I will likely be unable to find a locum to cover maternity leave… I am unwilling to go back to work 2 weeks after giving birth, and therefore will likely have to close my practice.*
- *If locums were more well remunerated/got bonuses, even in urban settings, I would be happy to help fill this void. I had to stop locuming because I was not making much income at all.*

SPECIALIST COLLABORATION AND FOLLOW-UP

- *Our clinic has to hire a full time MOA to manage referrals as the vast majority of specialists still mandate family physician offices notify patients of appointments and instructions.*
- *End the 6-month re-referral requests. This requires changes to the MSC fee schedule, which are long overdue. Put effort and time into changes that can be done quickly, not take years to deliberate.*
- *Today alone I have done 5 re-referrals for specialist care required for truly long-term issues (glaucoma, CHF, RA, sarcoidosis, MS). What a waste of everyone's time! Could we have a set of diagnostic codes that reflect the long-term nature of specialist care for defined conditions?*
- *Complex patients generate a lot of paperwork from specialists. As family physicians you have to review every consult note from every specialist your patient sees, or emergency visit they go to, as well as you get copied on every lab result ordered for your patients by every other specialist. … Depending upon your practice profile, this can be a full-time job all to itself, and it is entirely unpaid. It is also often how we spend evenings and weekends. I would often bring my laptop to social events to run through labs because it was either I bring it along, or I don't go at all.*

TECHNOLOGY/ELECTRONIC MEDICAL RECORDS (EMRS)

- *Stop using fax as a communication tool. It takes time to retrieve faxes and attach them to patient charts. It is 2022, and it should be available electronically in our EMRs.*
- *Please, find an EMR that minimizes or eliminates physician data and order entry. We should be spending time with patients, not clicking endlessly on a screen.*
- *As a family medicine resident who is rotating through a variety of services, the current limitations to the flow of information (from community providers to the local hospital system, amongst different hospital systems that use different EMRs, from specialized organizations such as BC-Cancer to hospitals, and across different*

TECHNOLOGY/ELECTRONIC MEDICAL RECORDS (EMRS) continued

health authorities) is staggering. This represents a completely needless barrier to information flow that has far reaching consequences. The costs to the system both in terms of duplicated investigations and sheer opportunity cost are appalling.

- *When I see a patient in ER, I cannot see the notes/tests from their family physician or internist who works in an office across the street. I cannot access the imaging they had yesterday at a private radiology clinic. I cannot see the notes/tests from the UPCC 5 blocks away that just sent them for additional workup. This not only creates a huge amount of unnecessary waste (redundant imaging, bloodwork, and referrals), but is also unsafe. (Specialist)*
- *Please stop all current EMR 'upgrades' until we have a consistent provincial strategy that includes hospital based and community based systems.*

VIRTUAL CARE

- *Virtual care should not be allowed or compensated unless there is an option to have the patient seen in clinic when/if a physical exam is required. It is appalling that Babylon can bill the same amount for virtual care as a longitudinal family physician for a consult.*

PRACTICE REQUIREMENTS/COLLEGE

- *The College's requirement for FPs to provide 24hr, 7d/wk, 365d/yr on-call coverage for no pay is a great burden and a big reason for many trained FPs not to work in community practice. Either establish equitable on-call remuneration, or set up a province-wide after-hours FP service that is paid well to address this immense burden*
- *I will not be forced to sacrifice my own well-being in a profession so demanding at baseline that we must take exceptional care of our own physical, emotional and spiritual wellbeing in order to not only survive, but enjoy.*

Comments on compensation

VALUE

- *Family practice is exceedingly more complex and difficult than it was even just a few decades ago. We are asked/expected to do more almost daily, with a current payment model that is not reflective of the work we do.*
- *GPs providing longitudinal care get paid the worst, are asked to fill gaps in care, and have less freedom than our colleagues. If there was a significant raise or bonus given only to GPs providing such care, that would go a long way towards making it more attractive.*
- *At the end of the day, when my accountant used information about hours (seeing patients, paperwork, answering calls, admin work, checking labs) vs pay to get an hourly rate after overhead it was found that community work = my pay is less than my MOA.*

- *My colleagues are being offered easier ways to make a living with better pay, defined hours, no on-call, and no overhead.*
- *Our pool of GPs has been diminished by many becoming hospitalists, providing mental health extension care, OR assists, ER physicians.*

VALUE continued

- *It is disheartening to know that a Nurse Practitioner can make comparable income to a GP, with the addition of extended benefits and a pension (at least in our community), no overhead (funded health authority position), no clinic management responsibility, and no on-call duties.*
- *Pay for all work, not just half or less. This is the best way to achieve equity in hourly rate with other FPs. A little of this and a little of that won't work. We're not going to stabilize, never mind turn around this crisis with tweaks.*
- *Pay longitudinal care appropriately. New grads aren't afraid of hard work. They're just making smart economic decisions. Until longitudinal care is financially competitive with other options available to new grads, it is dead in the water.*
- *I don't think it is a crime to be paid for personal benefit. Our profession demands more education and I would argue more personal sacrifice than any other. We deserve to be paid accordingly.*

COMPENSATION NEEDS

- *Increased net pay is the most important stabilizing action right now. FP Retention will be contingent on improved remuneration.*
- *Short term action would be a sharp increase in payment in order to help carry overhead burden.*
- *Net income should be the measuring stick. This must be flexible to fit different situations and geographic locations. Costs such as labor and rent vary highly.*
- *I think the fee for service (FFS) model works great. Each practitioner is able to work more or less as suitable to lifestyle and needs. What needs to increase is the remuneration for each fee.*
- *If you paid me to do the paperwork I have to do everyday, I can budget for that in my clinic day. We should be paid for ALL our time spent taking care of patients. This would include: 1. face to face time 2. charting time 3. time it takes to write referral letters*
- *Family Medicine billing codes need to go up by 30% now. Or the government must offer $84,000 / yr for overhead like they do for NPs. (With no strings attached). Or both! ...I've been a FP in rural BC for 20 years and my pay is the same now as it was when I started. My expenses sure aren't the same as 20 years ago.*
- *I've been on countless committees (GP For Me, PCN etc etc) which basically asked us all to become more and more creative with little extra funding and I am fed up. Just give me competitive remuneration and my burdens will all be manageable.*
- *A raise in business cost premium to account for these expenses is a quick and easy solution (I suggest it increase to 30% from the current 5%).*
- *I still provide good care to my patients either way, but I'll last longer doing it if I'm not stressed about my bottom line. I will happily run a business if I am compensated fairly enough to not worry about my bottom line with increasing costs of operating that business.*

EQUITABLE COMPENSATION

- *New payment model should consider the inequitable access to care in certain geographic areas of the province. You need to differentiate between urban and rural practice location including offering comparable incomes, time off, locum relief etc.*
- *Gender equity is a hugely important consideration that has often been left out of this discussion. Female dominated specialties (FM, psych, pediatrics, geriatrics)*

EQUITABLE COMPENSATION continued

are de-valued and underpaid compared to male dominated specialties. Patients have expectations that female family physicians will spend more time, and be more patient than male physicians. This attracts patients with higher care needs (mental health, chronic pain, elderly) that require more time per visit, and as a result female physicians are underpaid compared to male colleagues. Maternity leave is a major issue impacting female physicians.

- *There also needs to be equitable compensation across specialties: Currently Family Med, Peds, Psychiatry and OB/GYN have bargain basement remuneration. We are also "coincidentally" the specialities with the most female representation. These are some of the hardest and most demanding jobs in medicine.*

MODEL OPTIONS

- *It doesn't matter if a family physician is paid fee for service or by salary. What does matter is that the remuneration is the same at the end of the day. Same level of income for same level of work.*
- *The model isn't as important as the compensation. In a fee-for-service (FFS) world, the burden of running a clinic in terms of cost and unpaid administrative time is massive and severely under-recognized.*
- *Ensure flexibility in any system that's proposed so that we can each play to our strengths instead of trying to wedge us all into the same poorly designed box.*
- *The fee for service physician must be compensated adequately for overhead costs. … also compensated for the work he or she puts into running this business aspect, over and above the clinical services provided to patients.*
- *Contracts which propose fixed funding but yet expect physicians to administer their own clinics will, in my opinion, never work. Capping income but not capping costs will never be sustainable.*
- *The ability to choose the compensation model: not every physician wants to abandon FFS. I would prefer to continue to work in FFS, which allows me a great deal of autonomy…the solution to the primary care crisis is [not] contracts for all.*
- *If the FFS fee schedule were simplified and modified, contracts may not be necessary, as we would be paid for what we are doing. I think encouraging all physicians to work under contract has the potential to worsen the access to primary care.*

- *I'm not a lover of FFS, I have used it to my benefit with long hours to try and stay ahead, but it does not support best practice in my opinion, and is open to abuse…The Alberta model in the past is interesting.*
- *Ultimately, physician autonomy is very important. We must ALWAYS have a FFS option even if an alternative payment system is created.*
- *Increasing FFS payments would result in increased interest in attracting more FPs to provide all forms of care, and would come with the least administrative burden.*
- *If there is a hybrid model that gives GPs the option of FFS (at acceptable rates) or salary/ sessional contract I would agree with that.*
- *If there were more opportunities for physicians to work on contract in community or health authority run centres without business administrative and cost burden then contract positions become more attractive and viable.*

MODEL OPTIONS continued

- *As a practicing GP in the UK for nearly 7 years before moving to BC last year I can categorically say that we must not leave the current FFS model and move to a salaried based role. Whilst the idea of paid sick time and annual leave seems appealing, the long-term implication of a salaried contract will drive doctors away.*
- *Our group recently went on GP contract and we have PCN team based care. Working on contract has had its challenges. We will still end up working for free. Our panel size and work hours were underestimated. The Ministry has added hours of busy work. That being said, the concept has potential. It does support team-based care. I can delegate more and leverage technologies such as secure messaging. I spend more time with my complex patients. I appreciate the simplicity of billing but that gets cancelled out by the time tracking.*

MODEL CHARACTERISTICS

- *The model should compensate for time spent with patients and for clinical administrative time.*
- *The new payment model needs to be simple to administer, easy to transition to, and should be scalable to all interested family physicians in a very short time.*
- *Simplicity sounds nice, but I would rank as less important. I would hate for a great model to be ruled out because it is not simple.*
- *I think we must provide significant support to community longitudinal family physician payment (CLFP) for overhead support/ the cost of running a practice. Whether the physician is FFS or Contract or other, these costs are a huge burden. This needs to be an amount we can expect and rely on… a range of $100,000 per year.*
- *Consider alternatives: capitation, daily flat fee with patient daily/panel minimums (like rural locum) and additional amounts for seeing greater number of patients.*
- *A new payment model needs to consider the unique needs of rural family physicians. The APP contracts the government has previously offered did not work for us because we take time out of clinic to work in the ER and hospital. A comprehensive contract for rural family physicians is needed.*
- *Missing from this is that an ideal model should have very kinds of leaves built in - parental, maternity, sick, vacation, bereavement. Just because we are not employees does not mean we couldn't have these negotiated benefits.*
- *Increased admin reimbursement should not bring with it an added layer of micromanagement - the assumption being that people will buck the system if not monitored.*
- *Family physicians shouldn't have to feel pressured to see more patients in order to make the ends meet. This will only lead to compromised patient care, physician burnout and collapse of our healthcare system.*

MODEL CHARACTERISTICS continued

- *I worry about requirements for increased attachment for new funding, as I think huge funding is needed to just maintain current levels of care, before we reach a point of additional funding creating additional capacity. This is one of the reasons why my clinic declined the RNs/NPs from the PCN – the attachment numbers were quite high, and I need staff to help maintain my current roster of patients. The additional staff would not have created capacity to expand, and I would have signed contracts that I knew I couldn't meet.*

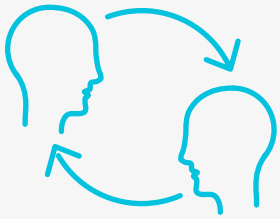
FEE FOR SERVICE IMPROVEMENTS

- *We deal with a lot of complex physical and/or psychosocial issues where there is no fee code. Instead of an increasingly complex fee schedule, we need to add time modifiers - including the time spent on all the paperwork that also has to be done to support that visit.*
- *Complex care fee codes in general are time consuming and prohibitive of many health issues (for example ADHD). I suggest that we increase the base fee codes and simplify them to begin with. Remove age codes. Remove all of the complex care codes, preventive codes. Instead, add time modifiers to the base fee code to allow us spend as much time as is required to deal with these patients. This could be done instantly.*
- *To date there have been "bonus billing" for chronic care but unless you hire someone to keep track of this it doesn't get billed because we are too busy seeing patients and spending hours every night to look at results, do forms etc.*
- *I really dislike the diagnosis-based complexity - how was that list of conditions decided? Why a bonus code for HIV clinical time but not dementia clinical time?*
- *Billing for time spent is much fairer than segregating patients based on diagnosis …We need a time-based system that does not exclude any patient and is fair for all.*

Comments from Specialists

Have Your Say online platform

- *Our FP colleagues need support, help, and access to more competitive funding models. If not, the model we have currently is not working, and not only drives away FPs, but is burning out the Emergency physicians, and worst of all, patients are left scrambling and feeling powerless.*
- *Not only does the emergency department (ED) function as the backstop of an already overburdened system, it is now being increasingly inundated by patients who cannot get timely access to primary care.*
- *With this increase in demand, the wait times for all patients increase, inefficiencies grow in the ED, patient and provider distress increase, patient deterioration and poor quality of care ensues as the wait rooms are much too full, and violence increases.*
- *It is very scary to work in emergency rooms (ERs) where the volume versus resources are so misaligned that it feels dangerous and risky now. Primary care needs to be bolstered emergently, for the sake of our ERs as well.*
- *We also have a severe lack of psychiatric and mental health resources, which leaves much of this load on family physicians. Increase psychiatry access and reduce wait times, reduce barriers to access. Offer funded counselling to MSP covered BC residents.*
- *All patients need a primary care practitioner. Medically complex patients need a physician in this role. Priority should be given to patients with multiple comorbidities.*
- *Grow the specialty so that patients are attached.*
- *With 20% of patients having no family doctor, I feel obliged to help those whom I am seeing for chronic conditions, with their other medical problems (as far as I can). I also continue to follow-up indefinitely in order to keep prescribing medication they need.*
- *Moral distress on the part of specialists being asked to practice medicine outside their area of expertise.*
- *ER physician here. The solution needs to reward chronic, complex care, in order to keep these patients out of the hospital as much as possible. Walk in clinics, UPCCs, and virtual platforms seeing minor acute complaints does not help EDs, because we are trained to deal with these complaints expertly and efficiently. What we cannot do well is provide longitudinal care to elderly patients who have been admitted in the waiting room for three days.*
- *ER Physician: I agree FPs should be called and treated as specialists, and fully support a model that would give FPs what they collectively determine they need to care for ALL patients longitudinally, and at the same time that would empower them and hold them accountable for a system that enables timely and ongoing primary care to be available for ALL patients, 24/7, including less desirable or complex patients and including in person assessments and exams.*
- *The referral system to specialists is in dire need of a makeover. We need central referral systems in each geographic area.*
- *Communication between primary care docs and specialists is still in the dark ages—faxes, posted letters, lack of communication over testing needs and results, needless tests, etc. In this modern day there are better, more effective ways of working together.*



Comments from recent Family Practice graduates

Virtual session

- *Fee for service is unsustainable for me at the moment and has made me consider leaving the province.*
- *I can't imagine taking on a practice and not being able to plan time off or have to rely on asking colleagues for help.*
- *I graduated from residency in 2016 and took on an already established large urban practice from a retiring physician that I was advised by one of the practice support personal had one of the most complex case loads in the city. Within three years of taking over the practice I have all but given up family medicine entirely, to focus on emerg.... taking on a complex case load takes 2 to 3 times longer per patient (initially), than for a doctor that already knows the patients (and doesn't have to review the charts from the beginning to sort out the patients' medicinal history). This is all unpaid time.*
- *Several of my new-to-practice colleagues have deferred starting practices because they don't want to be in the position of going on maternity leave and losing money. Not to mention that finding a locum to cover your practice is becoming an impossible task, and the stress of having maternity leave cut short is enough to drive many young female physicians away from taking on a panel of patients.*

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