RESIDENT AND NEW TO PRACTICE ENGAGEMENT PROJECT

DATA AND INSIGHTS REPORT

May 19th, 2023

Vancouver
Division of Family Practice
A GPSC initiative

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INTRODUCTION

Family physicians are the cornerstone of the health care system in BC, and the family physician community in BC has been shifting. A sizable portion of the practicing physicians are expected to retire in the next five years. Physicians entering the community have important perspectives and expectations of the system. Recent reports have highlighted the challenges related to attracting and retaining family physicians, leaving a critical part of our health care system at risk.

As residents and new to practice physicians will play an important role in primary care for the coming years, the Vancouver Division, through a series of engagement sessions, sought to better understand nuanced responses to this broad question: 'What attracts young physicians to primary care and how can we ensure to retain them in the system?'

The sessions aimed to capture these cohorts' perspectives on the current state of primary care, and the changes that are needed to improve our system and to retain them.

Exploration of topics and insights from these engagements will help inform future Division programming and identify areas of support that may require a regional/provincial lens.

Approach and Process

The Vancouver Division team designed five engagement sessions, each with three cohorts: new to practice, residents, and locums. Questions were designed to address five sub-components of the broad question from multiple angles:

1. **Choice of primary care as a career**
2. **Factors affecting where they practice**
3. **Current benefits and challenges of BC's model of primary care**
4. **Components of an improved (or ideal) primary care system**
5. **Longer-term career goals**

Following the fifth session, participants responded to a questionnaire design to clarify and nuance previously explored topics.

Sessions were conducted virtually with the help of the Mentimeter software, which was used to facilitate sessions, gather comments, and collect data from all responding participants.

It should be noted that these sessions were not designed as part of an academic research project. They were designed to promote dialogue and encourage discussions.

Analysis

The Division's team facilitated 15 engagement sessions and fielded one questionnaire.

At each session, prepared questions focused on a related element of primary care. Questions were designed to capture both qualitative and quantitative data. The data from ~130 questions were then analyzed per cohort and on aggregate. This approached helped to identify commonalities and differences among cohorts.

A number of physician champions provided subject matter expertise and helped guide the Division's team through out the engagement series.

Respondent Breakdown

Table 1 shows the number of participants from each cohort for each session as well as for those who responded to the questionnaire.

TABLE 1

Session	Participants			
	New to Practice	Resident	Locum/ Other	Total
1	15	24	7	46
2	12	19	5	36
3	13	22	4	39
4	10	19	4	33
5	13	19	5	37
Q'naire	12	18	6	36

High-Level Insights and Themes

The high-level themes that emerged, summarized below, appear frequently as threads responses. They are explored further in *Data and Results* section.

Flexibility – Many participants cited flexibility as a key factor for choosing family medicine. The majority value the ability to set their schedules and workload and appreciate the autonomy to choose where to apply their clinical and professional skillsets.

Variety – Participants want diversity in their work and highlighted the importance of variety in their practice focus, as well as the diversity of activities within and outside clinic settings.

Workload and administrative burden – A significant challenge to the majority of respondents is the amount of time spent and expectations related to the administrative burden of family medicine.

Work-life Balance – Respondents struggle with achieving and maintaining work-life balance, amongst rising financial pressures, system-level challenges, administrative burdens, and family needs.

Remuneration – An overwhelming majority of participants cited a need and demand for an overhaul of the remuneration model.

Overall sustainability- Many participants highlighted that without meaningful changes to the current model in BC, they would struggle to see family practice as a long term and sustainable career.

DATA AND RESULTS

In this section, we showcase some of the data and results from the participants in the event series. This his been broken into various sections to unpack important topics and themes for resident and new to practice physicians starting their careers in primary care, and what opportunities and supports they might seek.

WHERE TO LIVE AND WORK

As decisions about where to live and work are closely connected, respondents were asked a series of questions specific to where they choose to live, and what are the drivers of that decision for them.

The top five drivers of respondent's decisions for where to live, in order (highest first), include:

1. **Affordable housing for my family**
2. **Availability of work options (practices, hospitals, etc.) for myself**
3. **Proximity to or located in an urban center**
4. **Easy access to outdoor recreation**
5. **Availability of suitable work for my partner**

Province

Top drivers for choosing the country or province in which the respondents want to settle include proximity to family, lifestyle accommodations, work opportunities, and availability of work for their partner or spouse.

- **71%** of participants indicated proximity to home as a deciding factor in their selection

Urban vs. Rural

There were a diversity of preferences with respect to settling in an urban or rural community:

- **58%** of respondents indicated a preference for working and living in an urban community.
- **33%** indicated a combination of urban and rural working/living.
- **8%** indicated wanting to live and work in a rural community.
- More importantly, for **86%** of respondents, the urban/rural decision of where to work and live was consistent with where they completed their residency training.

WHICH COMES FIRST – FINDING A COMMUNITY TO LIVE OR FINDING A PLACE TO WORK (ALL)?

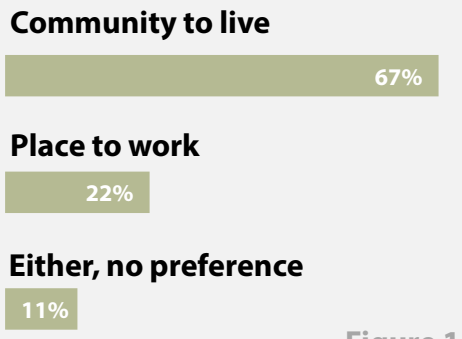


Figure 1

The timing of the decision of where to live and work is explored in Figure 1.

Choosing Communities

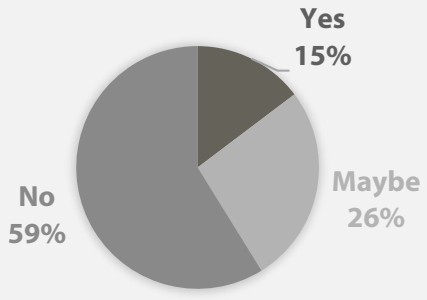
These answers were more nuanced and diverse.

- Common considerations include: affordability, proximity to family, safety, walkability, access to outdoors, good schools, bike paths, nearby amenities, sense of community, recreation, events, hobbies, access to nature.
- **49%** of respondents said they would consider or have already decided to work and live in the Lower Mainland.
- Most respondents cited the cost of living and/or housing prices as a big barrier for settling in some communities or reason for exploring other options.

- **59%** of respondents said they would not settle in the City of Vancouver, with the majority citing the cost of living as a main issue (see Figures 2 and 3).
- **75%** of participants also indicated proximity to home as a deciding factor in their selection (Figure 4)
- When asked about the timing of decisions related to selecting a more permanent place of residence and work, many participants mentioned other life events such as children and buying a house being an indicator of permanency.

DO YOU SEE YOURSELF SETTLING IN THE CITY OF VANCOUVER?

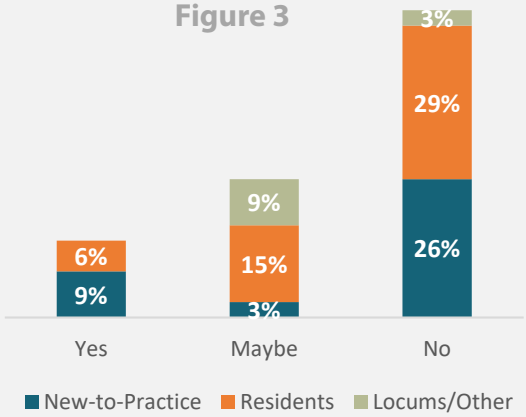
Figure 2



Aggregate response for all three cohorts

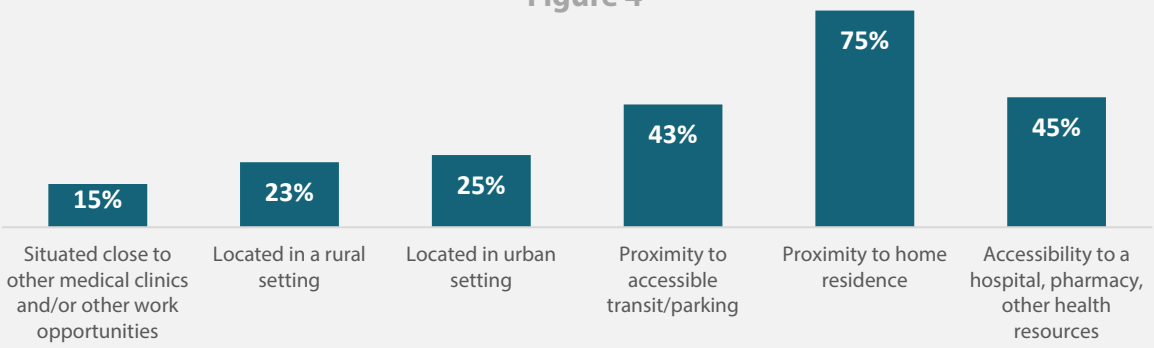
EXPECTATIONS OF SETTLING IN VANCOUVER BY COHORT

Figure 3



MOST IMPORTANT FACTORS WHEN CHOOSING A SUITABLE CLINIC LOCATION FOR WORK

Figure 4



Participants were able to select multiple answers. Percentages include the percentage of participants who indicated each.

PRACTICE PREFERENCES

Elements of practice preferences and their effect on personal and professional career of participants were a recurring theme in the engagement sessions. In this section we summarize participant responses to the related threads about their practice preferences.

Appeal of Family Practice

Some questions explored the drivers for residents and physicians to choose family medicine as a specialty in the first place. These factors are important to consider as they may highlight participants overarching priorities for their career and lifestyle.

When asked to rate the importance of the drivers in their decision to pursue family medicine over other specialties, the following four responses were consistent among all three cohorts:

- **Clinical interest/variety**
- **Work-life balance/flexibility**
- **Shorter residency timeline**
- **Independence/autonomy**

Other notable reasons for choosing family medicine were the desire to make a difference, build relationships with patients, and being able to manage families' care needs over the course of their life.

Practice Priorities

As highlighted above, physicians' affinities for flexibility, autonomy and choice are overarching influencers of a number of personal and professional decisions. The aim of this section is to unpack other criteria the participating physicians use to narrow down and select the practices or clinics at which they will work.

"I loved the continuity of care and wanted to make a difference"

The following provides some high-level considerations while the remainder of the section dives deeper into different elements of practices that residents and new to practice physicians look for.

To better understand factors affecting clinic or practice selection, the topic was revisited in multiple meeting. In some instances, the options provided to respondents varied based on discussions in previous sessions. The results point to flexibility in the participants selection criteria as demonstrated in the following three questions exploring clinic selection decision drivers .

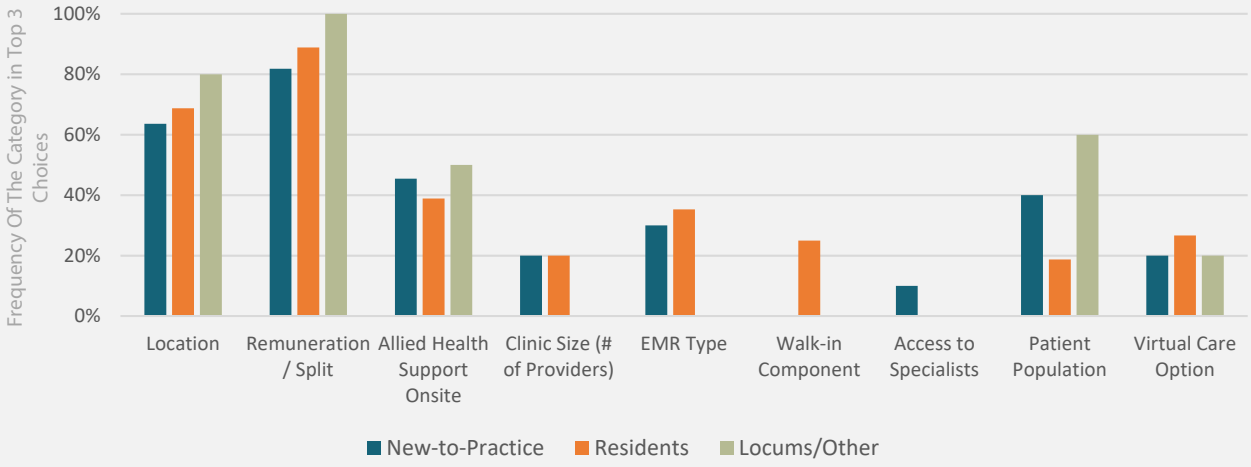
In the first instance, when participants were asked to select the most important factors guiding participant's decision about where to work (from a preset response list), the top five most prevalent responses were:

1. Flexibility in schedule (weekly hours and vacations)
2. Positive collegial environment
3. Great support/admin staff
4. Availability of my preferred remuneration structure (FFS, APP, contracts, etc.)
5. Effective clinic operations that allow me to focus only on practicing medicine

In another question exploring this topic, participants were asked to rank the reasons for choosing one clinic over another. The list of options were different but related to the previous question. Figure 5 represents the frequency of times each option was ranked among the top three choices of any respondents.

TOP 3 RANKED REASONS FOR CHOOSING ONE CLINIC OVER ANOTHER BY PARTICIPATING COHORTS

Figure 5



In addition to the frequency of appearance in the top three selections, the average rankings from all respondents to this question (as an aggregate) were analyzed to highlight the factors that are perceived as most important for differentiating between clinics (Table 2). Notable low-ranking responses to the question above were access to specialists, and presence of a walk-in component.

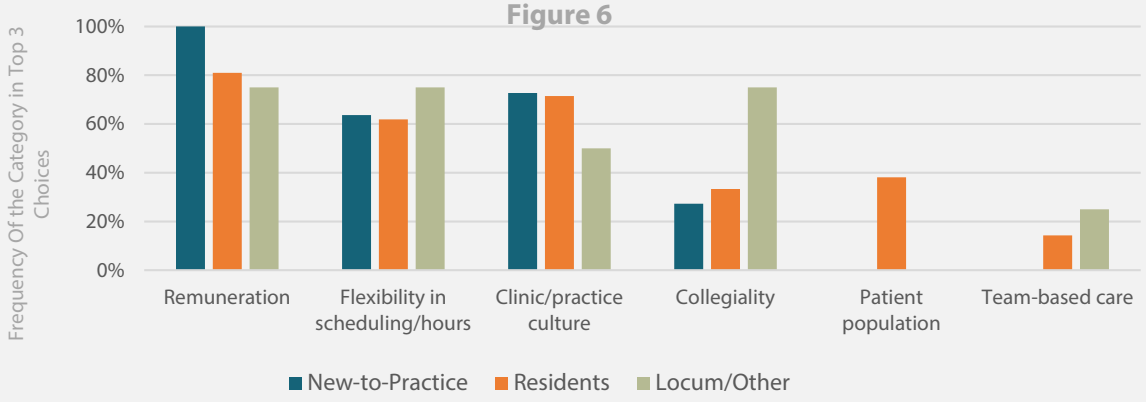
TABLE 2: AVERAGE IMPORTANT RANKING WHEN CHOOSING CLINICS (ALL)

Factor	Ranking
Remuneration / billing split	**1st**
Location	**2nd**
Patient population	**3rd**

In the third instance, respondents were asked what have they learned in their training or experience so far regarding the top 3 most important factors in a clinic, aside from location. The options provided to participants were guided by discussions in previous sessions and intentionally narrower than that of previous question; for example location, a main driver in previous question was removed to help further refine other decision drivers. The results are summarized in Figure 6 by cohort.

ASIDE FROM LOCATION, WHAT ARE THE TOP 3 MOST IMPORTANT FACTORS IN A CLINIC

Figure 6



Aggregate analysis of the responses, summarized in Table 3, helps identify the factors ranked as most important for this question.

It is important to note that the varied rankings to similar factors in these questions. Patient population and team-based care are two examples of this variability. This will be explored further in the discussion section.

It is also worth highlighting that other questions aimed to unpack highly ranked drivers further. These results are presented in relevant sections below. In one such case, in the *Practice Diversity* section, what flexibility means to providers is explored.

TABLE 3: TOP 3 MOST IMPORTANT FACTORS IN A CLINIC, ASIDE FROM LOCATION (ALL)

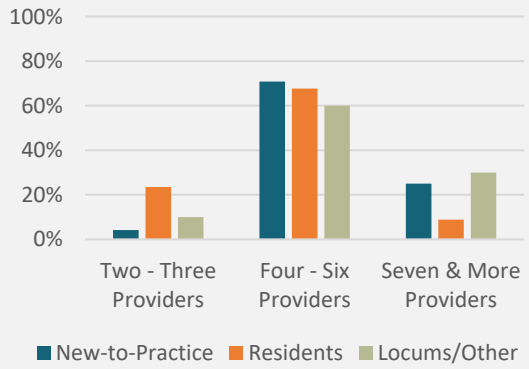
Factor	Ranking
Remuneration	**1st**
Clinic/practice culture	**2nd**
Flexibility in scheduling	**3rd**

Clinic Size

Participants preferences related to clinic size seem to have been influenced by the value they place on cross-coverage, collegiality, and individual autonomy. As summarized below, most participants indicated a predisposition towards mid-size clinics. Based on general observed trends, participants do not gravitate towards very small or solo clinics and are also hesitant to be "a cog in the machine" at larger clinics. Figures 7 and 8 highlight the relevant results. Please note that the categories below were not pre-selected; they have been compiled and categorized based on responses from participants.

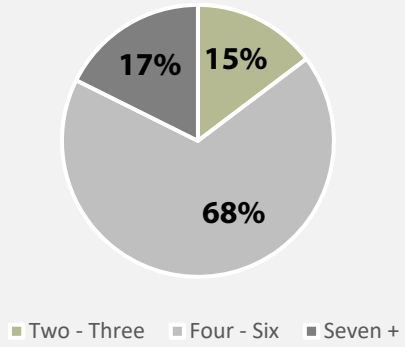
CLINIC SIZE PREFERENCES BY COHORT

Figure 7



OVERALL CLINIC SIZE PREFERENCES (ALL PARTICIPANTS)

Figure 8



Solo Clinics

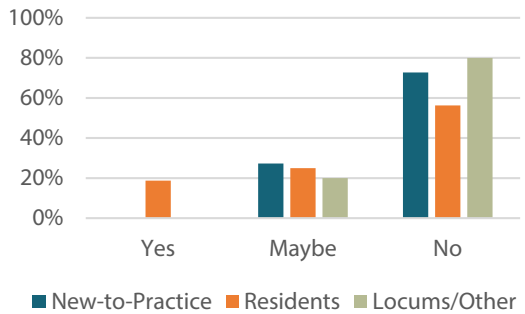
Figure 9 summarizes the cohort specific responses to whether participants would ever consider practicing in a solo environment. On aggregate, the frequency of responses were as follow:

- No – 66%
- Maybe 25%
- Yes – 9%

A follow-up question sought to understand the rational for these answers. In their responses, those who selected maybe or yes often noted conditions that would make practicing as a solo provider a more viable option for them. Common conditions included guaranteed locum coverage, attractive overhead, and allied health support.

ARE THERE ANY INSTANCES IN WHICH YOU WOULD CONSIDER A SOLO PRACTICE?

Figure 9

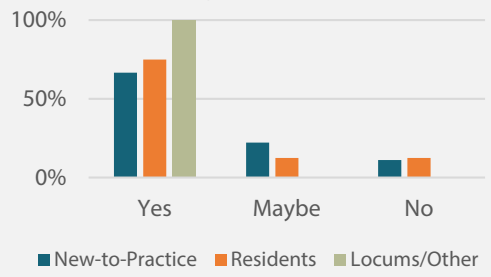


Large Clinics

To assess participants pre-disposition for working at very large or "mega" clinics, participants were asked if they would consider working at such clinics. Follow-up questions sought to understand the rational for their selection. The results are summarized in Figures 10 and 11 with a sampling of quotes below.

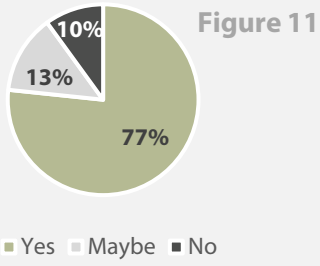
WOULD YOU CONSIDER WORKING AT LARGE "MEGA" CLINICS? (BY COHORT)

Figure 10



PARTICIPANTS WHO MIGHT CONSIDER A LARGE PRACTICE (ALL PARTICIPANTS)

Figure 11



"I would consider it (mega-clinics) if the overhead costs actually end up being a true economy of scale. This would need to be weighed against my decreased ability to influence how the practice operates, however."

"I feel like it depends on the specific management of the clinic. It needs to be responsive to MD feedback, able to flexible to different practice styles of different docs and foster a collaborative environment."

Medium Sized Clinics

Common reasons for physicians indicating a 'medium' sized practice include the following perceived benefits:

- Collegial relationships
- Cross coverage
- Good organization
- Positive culture

"I chose 3-5 practitioners, but having said that, I have seen clinics with 13+ practitioners (run) very well and (have) organized layout vs. clinics of 3-5 providers where there were more chaos and room confusion and less efficient space use."

Clinic Size Summary

Many other reinforce the view that the benefits of an efficient and effective group practice could be replicated in a small or large group setting. In participants views, the operations of the clinic are impacted the most by the organizational structure, leadership, and the colleagues. Many participants hinted at the importance of going beyond just the number of providers by looking at the clinic lay-out and the number of providers working at the same time. For example, the comment above by one participant garnered favorable comments from many others.

Team Based Care and Primary Care Networks

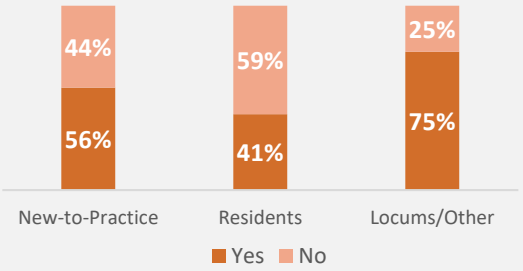
Team-based care is a generally accepted as an effective model for primary care in BC, however the participants highlighted that, as a province, we have a long way to go to achieve the intended goals and benefits associated with accessible team-based care.

All respondents indicated a group practice, not solo, as an ideal and realistic model for primary, partly because it enables incorporation of other provider types. Other questions, aiming to further contextualize these responses are explored below:

- On average, respondents perceived Registered Nurses (RNs), counsellors, and Social Workers (SWs) as most beneficial (Figure 13). Cohort specific variability in rankings is shown in Figure 14.
- Most respondents identify cost/funding as a barrier to integrating allied health providers in our primary care system.
- **48%** of participants stated that within reason, they would be willing to contribute a small percentage of their billing to help fund allied health at their clinic. Figure 12 breaks down the cohort specific variability in responses to this question. However, the participants felt strongly that in a sustainable system, family physicians should not bear these costs.

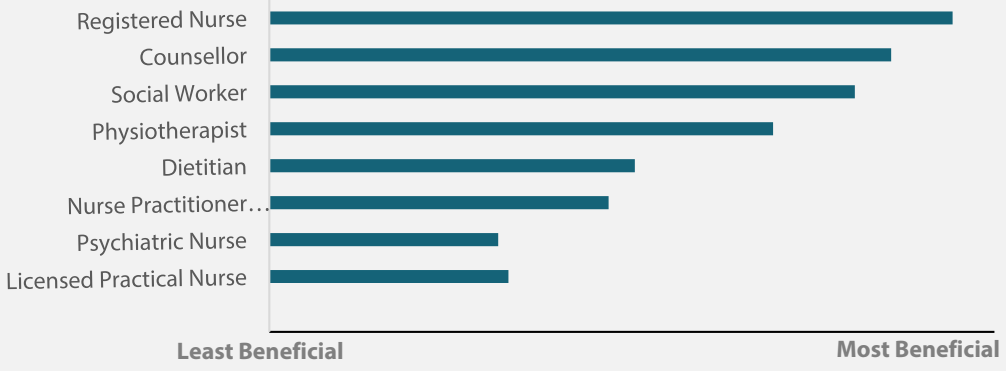
WITHIN REASON, ARE YOU WILLING TO CONTRIBUTE A SMALL % OF YOUR BILLING TO HELP FUND AN ALLIED HEALTH TEAM AT YOUR CLINIC?

Figure 12



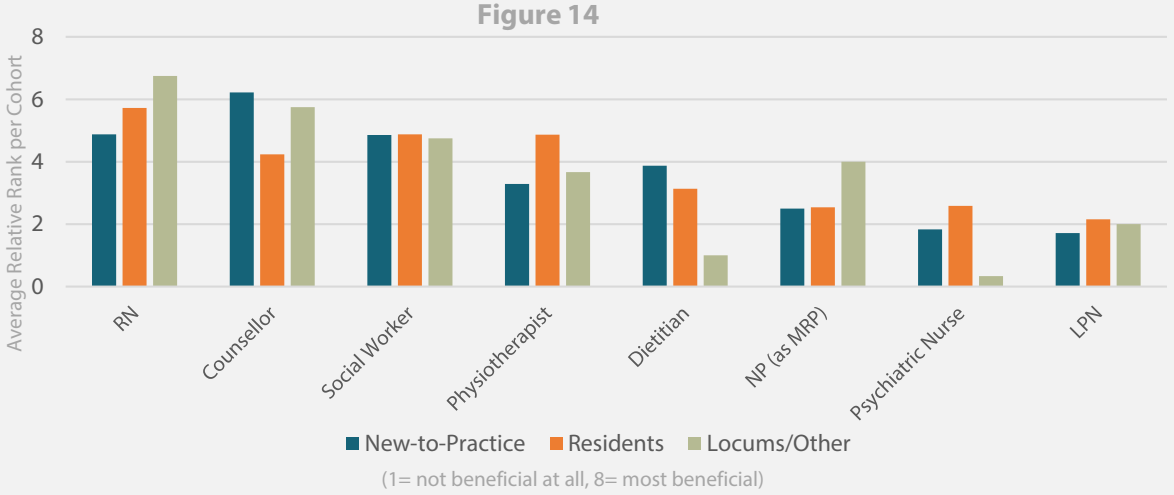
MEDICAL PROFESSIONALS VIEWED AS MOST BENEFITIAL ADDITIONS TO A COLLABORATIVE PRIMARY CARE TEAM BY ALL RESPONDENTS

Figure 13



PROFESSIONALS VIEWED AS MOST BENEFITIAL ADDITIONS TO A COLLABORATIVE PRIMARY CARE TEAM BY COHORT

Figure 14



In other related discussions and questions, the following findings were of note:

- Two of the most cited success factors supporting an effective team-based care model include defined roles and responsibilities, and open and clear communication.
- While many identified team-based care as an important element in supporting patient care, most did not vocalize team-based care as a deciding factor while choosing clinics. These answers seem to be conflicting and will be explored further in the discussion section.
- A common thread throughout the sessions was that participants appreciated the access to PCN resources and support. They also listed PCNs as a current system support they valued.
- A common response when asked about what technology or automation would be most beneficial for supporting team-based care collaborations or PCNs was a universal EMR, or a provincial record system for patient data. Better or improved patient education was also among a frequent response
- When participants were asked to rate the importance of co-localization of allied health in a team-based care setting, the average score was 3.3 (with 1 being not important ay and 5 being very important). Some representative comments are included below.

How important is co-localization of allied health in a team-based care setting?

"It would be nice to have the allied professional next door to ask questions and put a name to face, but otherwise it's not super important. I'll be faxed their report (hopefully) anyway.

"Makes life easier for the patients, they are more willing to attend appointments if they can be as close to a one-stop shop."

"The most important factor is that we have access to allied health in the geographic region, period. Less important that they are in the vicinity of my clinic."

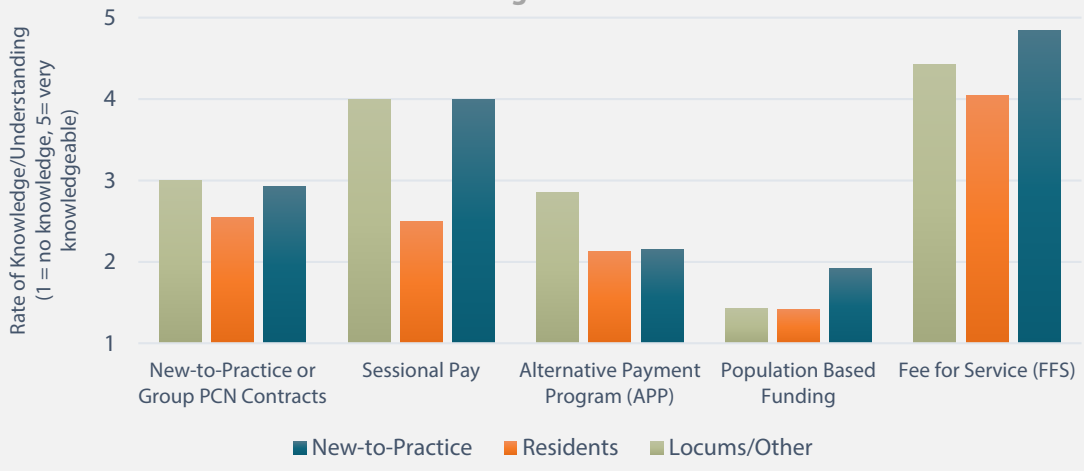
Remuneration

References to remuneration was a common theme in this engagement series. This report will not exhaustively summarize the feedback on the remuneration, partly because the provincial government has introduced a new model to address the common issues highlighted in the engagements. While implementation is underway, and no system is perfect, the demand for an overhaul has started to be addressed. With that lens, some related insights are summarized below:

- As shown in previous graphs, most respondents ranked remuneration as the most "competitive" factor that helps differentiate amongst clinics they consider.
- When participants were asked to rate their agreement with the following statement: "I am able to maintain my desired lifestyle and provide for others in family medicine" the aggregate score was **2.97** (1 – Strongly Disagree, 5 – Strongly Agree). However, it is important to note the responses were polarized, and not evenly distributed.
- When asked about Fee-for-Service (FFS), respondents noted that it hinders family physicians in many ways as it encourages less time with patients and doesn't support highly complex populations. Nevertheless, the respondents felt FFS supports efficiency and is an alternative to working for a Health Authority. Many respondents acknowledged no model is perfect, but the current model needs some updates and adjustments.
- Despite the identified challenges with the FFS model of remuneration, participants showed an overall greater understanding about FFS compared to other remuneration models. Most respondents were not well informed about the Alternative Payment Program and Population Based Funding (Figure 15).

RESPONDENTS DEGREE OF KNOWLEDGE OF COMMON REMUNERATION MODELS

Figure 15



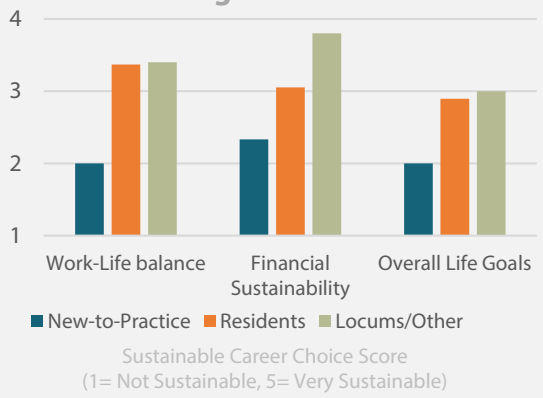
Work-Life Balance

Questions aimed to clarify the participants' subjective definitions of work-life balance. **In summary, definitions of work-life balance included being able to leave work at work, working reasonable hours, not having to sacrifice hobbies, family, sleeping, healthy eating or exercise, and having sufficient time for personal responsibilities and social life.** Highlights related to work-life balance are summarized below.

- As previously stated, perceived work-life balance of family physicians was a leading reason for choosing family medicine as a career choice.
- New to practice physicians rated family medicine, on average, as unsustainable (**2.0/5**) for work life balance. Residents and locums rated it more positively (**3.1/5 and 3.8/5** respectively). These results are summarized in Figure 16.
- On aggregate, respondents view an ideal work-week of approximately **40** hours per week, including administration.
- Respondents also reported currently working an average of **50** hours per week, inclusive of admin.
- **46%** of respondents indicated an overburdensome administrative workload as being a leading reason they find primary care unappealing and unsustainable as a career choice.
- Many respondents also felt that they often need to accommodate work after hours, which contributes to a loss of work-life balance.
- When asked what has helped participants achieve work life-balance, responses included commentary about shifting to working part time, setting better boundaries, and changing their primary work setting.

PERCEPTION OF FAMILY MEDICINE AS A SUSTAINABLE CAREER CHOICE

Figure 16



Flexibility

Desire for flexibility was another overarching theme that influenced multiple facets of participants career preferences from career diversity to place of practice. Takeaways from relevant discussions and questions follow. **Like work-life balance, definitions of flexibility varied among participants. Respondent's common definitions included independence and autonomy related to location(s) of practice, variety of work, work schedule, and time off.**

- Among all three cohorts, flexibility was among the top three reasons that make family medicine an attractive career choice.
- On aggregate, **43%** of respondents cited flexibility as one of the leading reasons they chose/choose family medicine in the first place.
- **56%** of all respondents stated flexibility among the leading reasons for currently finding primary care an appealing career choice.
- All locums cited flexibility as an appealing aspect of primary care; this cohort has also chosen the least amount of permanency in current roles.

Practice Diversity

Throughout this engagement series, the desire for practice diversity surfaced as a valued aspect of a family practice career that not only influenced choice during residency but also continues to guide respondents' practice preferences, from choosing clinics to commitments to patient panels. A summary of discussion and responses are provided below.

- As shown in Figures 17 and 18, **41%** of all respondents state they expect to spend more than half of their working time in community family practice settings. An additional **32%** of respondents plan to spend 26-50% of their time in these settings. Among the cohorts, **58%** of new to practice and **28%** of resident respondents plan to spend more than half of their time in community family practice settings.
- When working or planning to work at family practice clinic settings, on aggregate respondents indicated a desire to spend approximately half (52%) of their patient facing time either virtually or over telehealth.
- Many participants highlighted other and complementary interests they plan to pursue as part of their career . Some included:
    - Research and teaching
    - Practicing at other clinical settings practices (surgical centers, clinics with specialized populations, palliative care, public health, urgent care centers, etc.)
    - Working at hospital both in clinical and leadership capacities
    - Participating in working groups or committees
    - Represent colleagues, in governance and advisory roles within organizations and advocacy groups (Doctors of BC, Divisions of Family Practice, Family Practice Services Committee, BC Family Doctors, Health Authorities & Hospitals, Ministry of Health, etc.)
- **In terms of professional balance, when asked what an ideal work week would look like, 94% of respondents prefer to divide their time between two or more work settings in a given week (e.g., 1 day at a UPCC, 2-3 days clinic, ½ day long term care). This trend persisted between the cohorts (Figure 19).**

WHAT PERCENTAGE OF YOUR WORKING TIME DO YOU EXPECT TO SPEND IN A COMMUNITY CLINIC FAMILY PRACTICE SETTING?:

Figure 17

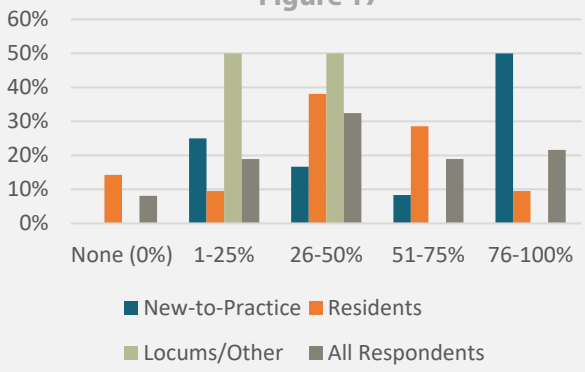
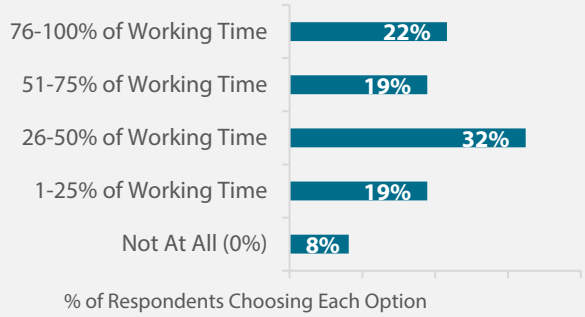


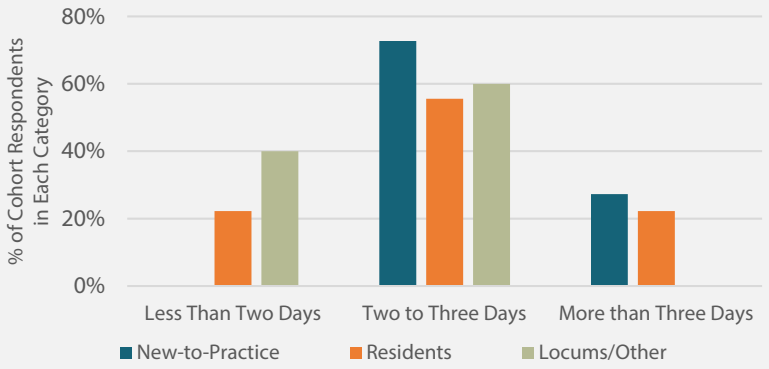
Figure 18



- Consistent with the results above, only **21%** of all respondents, including only **27%** of new to practice and **22%** of residents, anticipate working more than 3 days per week at a family medicine clinic (Figure 19) .

ANTICIPATED DAYS OF WORK PER WEEK AT FAMILY MEDICINE CLINIC BY COHORT

Figure 19

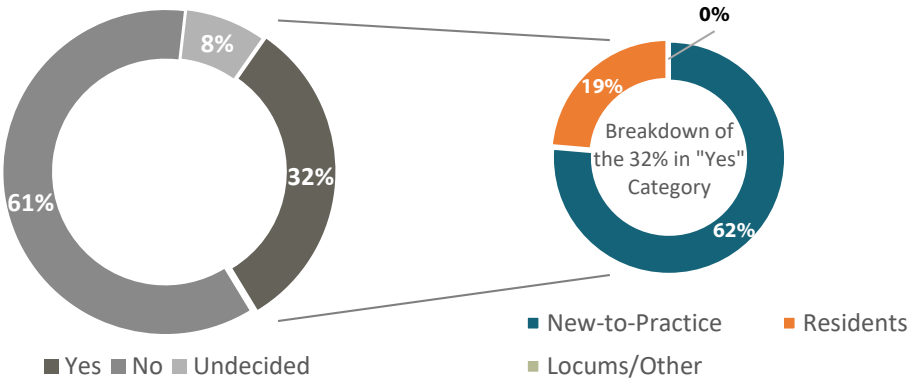


Commitment to Patient Panel

- Overall, **32%** of respondents would consider starting their own patient panels within the first three years of their career (Figure 20). Most participants aren't rushing into that decision, but are waiting for other life elements to align before committing.

WOULD YOU/DID YOU CONSIDER STARTING YOUR OWN PATIENT PANEL EARLY IN YOUR CAREER (WITHIN THE FIRST THREE YEARS)?

Figure 20



- When asked what starting a patient panel means to participants:
  - Respondents highlighted a realistic understanding of what starting a patient panel means in terms of responsibility, administration, and long-term commitment.
  - Many participants also highlighted the long-term relationship with patients and ability to manage their care throughout their lives. This was viewed positively by the group.
  - Other respondents were apprehensive of having a permanent practice panel because of the challenges with taking time off, the lack of flexibility, and the increased paperwork associated with a permanent practice.
- Other related questions explored participants views on an ideal patient panel size for a full-time equivalent (FTE) family physician. The responses varied significantly, ranging from 650 to 2000 patients. Many participants note that the panel size would depend on the type of practice and the patient population.
- To explore perception of permanency related to both personal and professional lives, participants were asked at what point in their training/career they had made or would make the decision on where to live and practice permanently. Although responses varied, many mentioned other life events such as having children or buying a house as being an indicator of permanency which translates to a permanent practice location.

Clinic Ownership

When asked about preferences of working at physician-owned vs corporately-owned clinics, **58%** of respondents favored physician owned clinics, while **39%** are open to both physicians owned and corporately owned options (Figure 21). Among the cohorts, new to practice participants favored physician owned clinics by a larger margin that residents or Locums (Figure 22). Those who were open to either, indicated that the nuances of the opportunity would guide their decision..

WOULD YOU PREFER TO WORK IN A PHYSICIAN-OWNED CLINIC OR A CORPORATE-OWNED CLINIC?

Figure 21

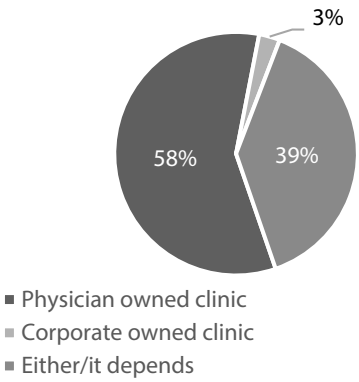
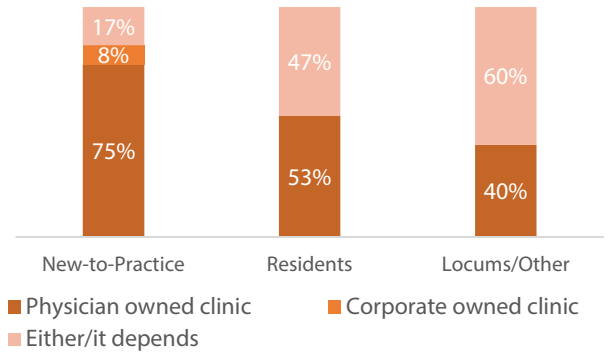


Figure 22



Discussions and responses highlighted that past experiences do not necessarily influence respondent views about preferred ownership structure. As showcased in a sampling of representative quotes below, participants appreciated owners with physician perspective but recognize the need for those with adequate business expertise.

"Both have their benefits and disadvantages. I can't say which is one better or not"

"Physician owned because there is incentive to work harder and you control the values of your clinic and type of services, as well as your income."

"Physician-owned preferred as long as they are business-savvy."

"In my experience - corporate owned means that ultimately profit is an important factor and that is not how I want to deliver patient care"

When asked if participants wanted to be clinic owners:

- **51% of the respondents do not have any interest in owning a clinic.**
- **34% are interested in being a clinic owner.**
- **14% are unsure/undecided.**
- **When comparing the cohorts, residents showed the highest interest in clinic ownership at 50%, followed by new to practice providers at 42%, while none of the participating locums are interested in clinic ownership.**

"I like the idea of being my own boss and owning a business, but it is very intimidating with all the politics and news and barriers for family physicians nowadays"

"The work load is deterring me - including hiring/training of staff, dealing with conflicts, trying to keep the doors open due to high costs."

"I entered medicine to take care of patients, not run a business/ spend my free time doing admin/ stressing about overhead/ managing staff, etc."

Respondents were also asked about the drivers of their interest or dis-interest in clinic ownership. The results, summarized in Figures 23 and 24, show that the two leading reasons for lack of interest were the perceptions of financial risk and the increased non-clinical time commitment. The two leading reasons for wanting to be a clinic owner were ability to influence clinic operations/ model of care and increased autonomy.

IF YOU ARE INTERESTED IN CLINIC OWNERSHIP, RATE THE IMPORTANCE OF THE FOLLOWING POTENTIAL BENEFITS

Figure 23

IF YOU ARE NOT INTERESTED IN CLINIC OWNERSHIP, RATE THE IMPORTANCE OF THE FOLLOWINGDRIVERS IN YOUR DECISION?

Figure 24

OTHER PRACTICE SUPPORTS

To better understand the perceived value of currently available supports as well as potential unmet needs, a series of open-ended and guided questions were posed to participants. This section summarizes some of these results.

Current Available Supports

Respondents were asked what current or existing supports from other organizations they value most. The results varied. Common responses included Pathways, Divisions, the RACE line, Up-to-Date, Care Connect, and PCN resources.

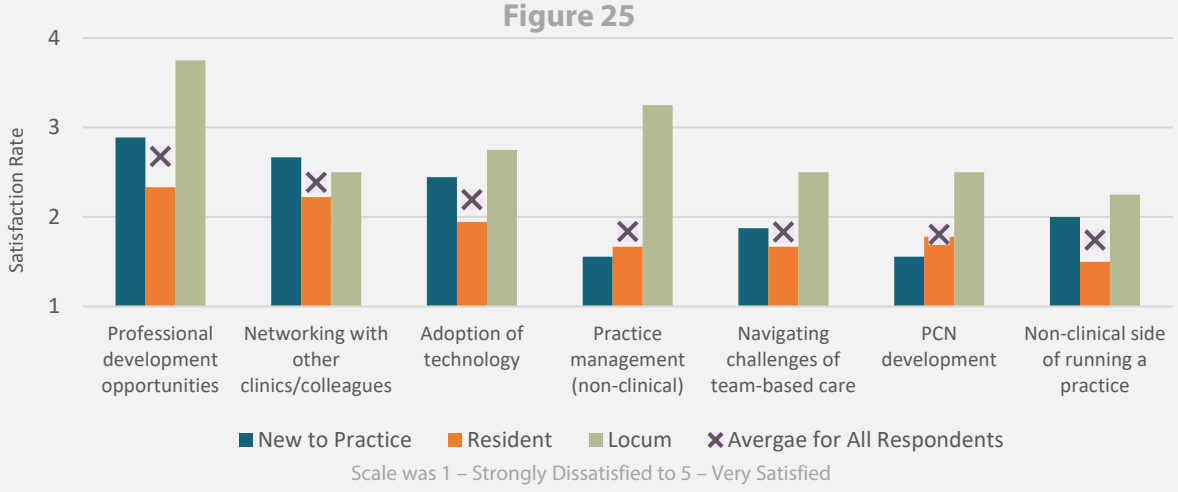
Another related question asked participants to rate their understanding of resources available to them from various organizations. The results suggest the highest level of familiarity with resources offered by the Divisions of Family Practice followed by Doctors of BC, BC Family Doctors, and Family Practice Services Committee. Respondents were least familiar with resources offered by Practice Support Program and Ministry of Health. It should be noted that as these sessions were being hosted by Divisions, there risk of sampling bias is non-trivial.

To explore areas of unmet or limited support, respondents were asked to rate their satisfaction with the overall availability of supports from selected categories. As shown in Figure 25, the results show lower levels of satisfaction (<2.0 out of 5, where 5 is very satisfied) with supports related to:

- Non-clinical side of running a practice
- Navigating challenges of team-based care
- PCN development
- Practice management

SATISFACTION WITH THE OVERALL AVAILABIILTY OF THE FOLLOWING SUPPORTS

Figure 25



Scale was 1 – Strongly Dissatisfied to 5 – Very Satisfied

Additional Supports

In a series of open-ended questions, participants were asked to identify or anticipate other system resources and initiatives that would help support family physicians in their careers. Table 4 summarizes the main categories of potential supports identified in responses.

TABLE 4: Suggested System Supports

Allied Health / Team Support ▸ Mentorship programs ▸ Peer support programs ▸ Access to allied health ▸ Assistant/staff to help with vitals, inbox, vaccines	**Work Life Balance / Admin Workload** ▸ Support finding and remunerating locums ▸ Mental health support ▸ After hours care program ▸ Support reducing paperwork and admin
Finance / Remuneration ▸ Revision of the payment model ▸ Benefits ▸ Pension ▸ Stat holiday pay ▸ Financial incentives to work off-hours (e.g. weekends) ▸ On call support or stipends ▸ Billing support ▸ Simplification of billing process	**Training / Resources /Other** ▸ Training for how to run your practice, resources in the community, and how to set up a clinic ▸ Centralized EMR ▸ Basic business training ▸ Supportive programs for transitioning to practice ▸ Access to plug and play medical spaces ▸ Group purchasing ▸ Charting workshops ▸ Medical scribes

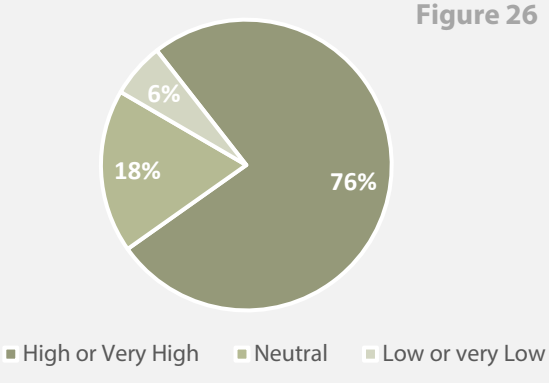
Technology Integration

Advances in relevant technologies may help increase efficiencies in primary care, however, in the past adoption of technology in primary care has lagged other sectors. To gauge upcoming trends, participants were asked to rate their appetite for adoption of technology in primary care practices. **76%** of respondents indicated high or very high appetite for technology (Figure 26).

Responses to related questions suggested areas in need of further technologies including, but not limited to, improvement of EMRs, improvement in data analytics and automating processes.

APPETITE FOR INCREASED ADOPTION OF TECHNOLOGY IN PRIMARY CARE PRACTICES (ALL PARTICIPANTS)

Figure 26



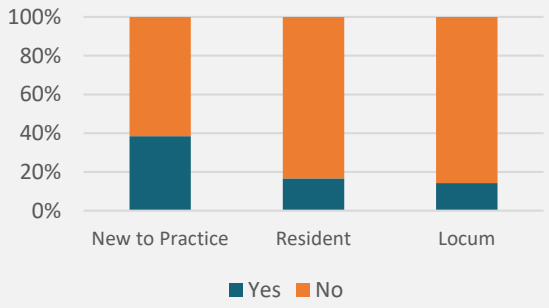
Non-Medical Training

When participants were asked what could have been done in residency to better prepare them for the non-clinical slide of primary care, answers included:

- Practice management courses
- Shadowing clinic owners
- Curriculum for personal finance, financial literacy
- Boot camp(s) for what you need to know to manage staff
- Best practices for charting efficiency
- Business training
- Billing training
- Orientation of community resources

I WAS GIVEN ENOUGH NON-MEDICAL EDUCATION IN PRIMARY CARE TRAINING

Figure 27



Responses to related questions, exploring which areas of navigating the business side of medicine respondents were least comfortable with, highlighted the following as the top three topics/areas:

- Clinic ownership
- Contract negotiations
- Administrative tasks

Other lines of inquiry, suggested that despite the positive perception of Primary Care networks (PCNs) as a whole, participants were not clear about some of the elements of the PCNs.

- When asked if they know what it means to be part of one PCN versus another, **87%** of respondents said they did not.
- When asked if they were taught about PCNs in residency, **76%** said they were not.

COMPLEMENTARY PROFESSIONAL SUPPORTS AND INTERESTS

Leadership

Many participants across cohorts plan to pursue leadership opportunities as part of their career. A series of questions sought to better understand leadership related goals and potential support needs.

When asked to rate the importance of traits in an effective leader, respondents on average favored the following as the top three characteristics:

- Being a skilled communicator
- Having knowledge of the current system
- Being a compassionate coach

Top themes participants identified when asked what leadership in their careers means included:

- Committee and working group involvement
- Advocacy
- Teaching
- Governance & implementation of initiatives

At their place of practice (current or future), **85%** of all respondents would be interested in joining the leadership team (Figure 28).

Mentorship

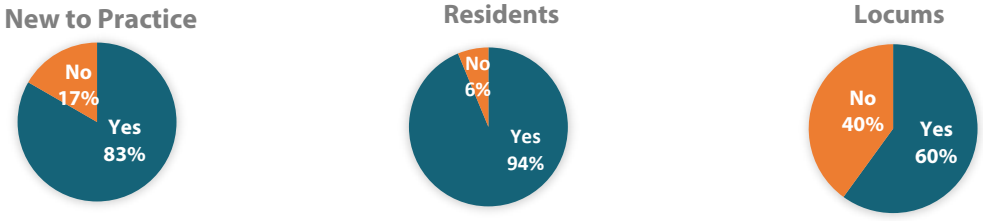
Mentorship-related goals and potential support needs were also explored.

Participants definitions of mentorship varied and included having someone that can provide practice related guidance, help navigate career decisions, and act role model.

Responses to mentorship-related questions show:

- **78%** of all respondents say they seek out mentors or experienced physicians for guidance
- Mentorship is most helpful in residency and early in physician careers.
- **76%** of those who have/want mentorship, prefer an ad-hoc mentorship relationship, while **24%** favor a structured mentorship arrangement.
- The three most valuable areas for mentorship include:
    - Practice management
    - Clinical and patient related matters
    - Career decision-making

FIGURE 28: ARE YOU INTERESTED IN JOINING THE LEADERSHIP AT YOUR CURRENT/FUTURE CLINIC?



Patient Diversity and Inclusivity Support

Majority of respondents indicated that their workplaces don't have formal or meaningful Equity, Diversity, and Inclusion (EDI) policies and practices. Most physicians, however, are interested in improving their clinic's EDI practices and offered practical suggestions for doing so. Table 5 outlines some of these specific suggestions.

TABLE 5: Participant's Ideas for Improving Patient Supports

Training and Staff

- Consider extending EDI training to other staff like MOAs (including paid time for participation)
- Encourage or provide courses on cultural and diversity sensitivities
- Ensure front staff who are specifically trained in these principles
- Invite experts to speak and advise on appropriate patient centred care
- Social worker involvement to navigate if needed
- Small things make a big difference (e.g. perhaps more cultural events)

Collateral, Communication and Resources

- Simple wording and easy to navigate websites
- Signs in many languages
- TRC poster in waiting room, signs as LGTBQ2+ allies
- Language interpreters that are easily accessible
- Access to resources for new immigrants
- Audio to sign language interpreters.
- Free samples/hygiene products/snacks for lower SES
- More refugee and immigrant health, other supports for low SES and vulnerable populations

Infrastructure and Administrative

- Adding notes to charts/communicate with staff if a certain individual has a preference with how they identify (i.e. pronouns etc.)
- Change the new patient intake forms (gender etc.)
- Appointment availability off hours, compassionate policies regarding no shows.
- External audits for opinions, or internal reviews to see if clinics are meeting the demands
- Have clinic policies and disciplinary measures when cases occur. Ensure that it is advertised and that there are clear reporting measures.
- Wide hallways and wheelchair accessibility
- Gender neutral washrooms

CLINIC AND SYSTEM INSIGHTS

The valuable insights and data gleaned from the engagement sessions not only identified the elements that are important decision factors for the resident and new to practice cohorts, but also identified potential complementary areas for clinics, system partners, and Divisions to prioritize for further attention.

In each of the sections below we outline key themes from the resident and new to practice engagement sessions that might have actionable implications for individual clinics and the system partners. Although the respondents identified these common themes in relation to different topics, the format or avenue through which these topics are addressed could vary. It is noteworthy to consider that irrespective of the current challenges affecting the clinics and the overall health care system, it may be important to try and find solutions to challenges raised by the resident and new to practice physicians to improve regional and provincial recruitment and retention efficacy.

CLINICS

The bulk of the engagement sessions focused on understanding the factors that help participants differentiate clinics from each other as they find their professional home. The sessions revealed valuable insights that might help clinics refine their recruitment and retention strategies. Many of the areas discussed impact the clinic operations or culture. While adjusting clinic operations or culture is voluntary and likely challenging, it might reward those willing to adapt and accommodate, within reason, with better prospects of finding and keeping physicians at their practice.

The five themes discussed below surfaced during multiple instances spanning various sessions. In each instance, the data was used to suggest potential actions for clinics to consider.

1. Flexibility and Scheduling

The data in the previous earlier sections highlights that a priority of the incoming cohort of physicians tends to be flexibility. This can mean both flexibility in scheduling (work week, vacations, etc.) as well as flexibility and autonomy in professional focus (such as patient types, specialized procedures, number of overall patients per day, etc.).

In recognition of this, clinics might consider:

- Developing baseline guidelines for physicians to follow with respect to schedule flexibility. These guidelines may include a reasonable lead time to request vacation, and regular scheduling processes.
- It would also be important to discuss the division of efforts needed to ensure adequate locum coverage to accommodate flexibility. In some instances, the clinics can work with all providers to recruit long-term locums to ensure all providers can take time away from the practice when needed.
- When locum coverage is not possible, it may be valuable to establish clinic policies that allow for cross-coverage while providers are away. Potential examples to be further explored include walk-in period for clinic patients to accommodate for emergencies, or reserving a portion of other providers' time for cross-coverage.

2. Diversity in Opportunities

Similar to the flexibility, physicians are also looking for diversity in their practice opportunities to balance their career. For many this might mean community family practice would only comprise a segment of their work week, while they might also seek out one or two other alternatives to diversify remuneration streams, create more learning opportunities, and gain experience with wider patient population. To accommodate this, clinics might need to:

- Adapt to support 0.5 FTE practices, shared practices, or at least less than full time work at primary care clinics.
- Potentially help facilitate other work opportunities for physicians. For example, they may be able to partner with a nearby UPCC, or Long-Term Care facility, to support their physicians set up additional shifts to round out their schedules.

3. Remuneration

Overall remuneration models in the province remain largely out of the control of family practice clinics. The sessions, however, did note that remuneration was the leading factor when deciding between clinics for work. For clinics to remain competitive, they may want to:

- Continue to review and revise their business model to firstly remain sustainable and operational, but secondly adjust overhead structures to offer fair and competitive remuneration models for physicians.
- Consider incentivizing providers that are willing to commit to full time work.
- As appropriate, provide transparency about clinic financials and help incoming cohorts better understand the components of overhead at their clinic as well as the risks involved in running the clinic.

4. Leadership

The discussions highlighted a significant interest from the residents and new to practice physicians to be more involved in clinic leadership. It is important to note that involvement in leadership did not translate to interest in the ownership, but rather supporting and influencing clinics policies, operations and strategic plans. Clinics might consider:

- Pairing incoming physicians with more experienced providers that can help them develop as pragmatic leaders. Additionally, this type of collaboration can facilitate learning in both directions.
- Create a development plan in collaboration with interested physicians that aims to aligns physicians areas of interest with clinic needs. Involve incoming physicians in operational leadership capacity, to support their development and lower the management burden on clinic leads.
- Use challenging situations as trainable moments for interested physicians and get a second view on the problem.
- Partner with other system players to facilitate training in human resources management, operational planning and leadership. There is a balance between managerial duties and tasks and remuneration for those tasks, and getting input and insights from physicians that a clinic can implement. Clinics really interested in designing and delivering a model that caters to physicians might consider trying to involve more of them in this type of planning.

5. Patient Supports

Residents and new-to-practice physicians were interested in receiving support from variety of sources to help them provide accessible and inclusive care to a diverse group of patients. In this regard, the clinics may want to:

- Curate and implement policies and procedures focused on nurturing a culture of inclusion.
- Connect with Divisions, system partners, and provincial resources to acquire resources that can help support patient with diverse needs and backgrounds.
- Identify educational opportunities for physicians and staff that can help provide appropriate cultural sensitivity training and resources.

SYSTEM

The engagement sessions also generated insights related to valued services, training, and supports that may be suitable offerings from a variety of system partners. Although these services may not provide a clinic-specific advantage, they will hopefully better support residents and new to practice physicians as they transition to their family practice careers. One of the aims of this project, was to identify what supports the system should wrap around this new cohort of physicians to encourage sustainable and fruitful careers. The five themes discussed below represent the most common relevant elements of the discussion.

1. Remuneration

While initial consultation of this project started prior the introduction of the LFP, much of the feedback captured related to the need for remuneration review across the province. This has largely been addressed, and the province has provided new and increased opportunities to remunerate longitudinal family practice physicians. However, the system players may still want to consider:

- Providing training on the nuances of various available models.
- Providing guidelines and education related to common elements of overhead.
- Partnering with educational institutions to train incoming cohorts on effective negotiations and management courses.
- Partnering with other organizations to ensure incoming physicians receive unbiased personal finance education.

2. Benefits

Many respondents indicated access to adequate extended benefits plan was a challenge. As many family physicians are independent contractors, and benefits aren't typically included for those roles, the provincial groups might want to explore:

- Further supporting the development of extended benefits plans for its physicians offered through third parties.
- Developing guidelines and education on how best to structure/utilize health spending accounts, when appropriate.

Similarly, another common element of discussions focused on the challenges associated with taking (unpaid) maternity or paternity leave early in their careers. This tends to coincide with large amounts of student debt, and the financial challenges associated with time away from work. In this regard, the system partners may want to explore:

- Potential financial support to delay or reduce student loan payments.
- Developing an avenue to financially support providers taking maternity and paternity leave that can help augment/increase the limited EI benefits.
- Providing training to residents and new-to-practice providers on how to structure their incorporations to plan for anticipated personal leave.

3. Mental Health Support

Many providers also highlighted the challenges that accompany burdensome practice, lack of work-life balance, and at times social isolation due to work as creating a heavy mental health load. System players may want to consider:

- Providing subsidies for relevant supports (such as counselling, meditation, etc.).
- Facilitating group sessions for those experiencing similar issues, discuss challenges and share strategies
- Developing networking series/events/other activities for providers and their families to help them feel more connected to the community.
- Continued promotion and building on the supports offered through the Physician Health Program (PHP).

4. Education and Training

A common thread through these sessions included a lack of non-medical training that is essential to be successful with a career in primary care. It would be beneficial for system partners to consider:

- Collaborating to identify suitable delivery mechanisms for the key topics highlighted in the Non-Medical Training section (page 24) that were identified as areas of interest during the engagement sessions, to support residents and new to practice physicians prepare for their career as they become established in Vancouver.
- While a variety of different types of supports could seek to fill this gap in knowledge, a “low- hanging-fruit" for non-medical education would be to include more robust training in residency about popular and important topics (practice start-up, practice management, HR, etc.) prior to graduating and entering the workforce.

5. 24/7 Physician Access

A common challenge raised by participants was the College requirement to be available 24/7 for patients of a practice. Many participants felt that the need to always be available to patients is unrealistic. Some also felt that uncertainties with risks that accompany sharing patient care in a team-based environment has exasperated this challenge. It would be beneficial if the relevant system players consider:

- Revising this requirement to reflect the changes in practice styles and team-based collaborative care.
- Develop guidelines and funding for UPCC or other organizations to provide after hours care.
- Develop a centralized system that can facilitate after-hours triage and patient sharing based on clinic EMRs.