Leaning in post pandemic

Francine Lemire MD CM CCFP FCFP CAE ICD.D, EXECUTIVE DIRECTOR AND CHIEF EXECUTIVE OFFICER

Dear Colleagues,

With rapid development and accelerated distribution of coronavirus disease 2019 (COVID-19) vaccines and gradual lifting of public health restrictions, we may be heading for a more relaxed end of summer and fall. The pandemic uncovered important gaps in care—eg, elder care, particularly in private long-term care, and the depth and pervasiveness of systemic racism. We must reflect on the lessons learned and continue important conversations—some necessarily difficult—about how best to design the health care system to meet peoples' needs. Here are a few areas to consider, often discussed by the CFPC leadership.

Investment in prevention and better integration of public health in family practice: Although there were notable public health efforts in some jurisdictions, there should have been better integration between family practice and public health. For example, 43% of family physician respondents to a recent CFPC survey were not engaged in reporting COVID-19 cases to public health authorities, and only 32% were invited to identify priority populations for vaccination. Further, half of respondents were unclear about governments' responses regarding the role of family physicians in the pandemic. Let us learn from this to prepare for the next pandemic. Furthering opportunities for learning, the CFPC is participating in an international study on COVID-19 vaccination, helping us understand the global picture.

Deliberate strategies to enhance equity of access to care: This applies in particular to marginalized populations, racialized groups, immigrants, refugees, and those living in rural or remote areas. This will not be possible without dedicated attention from all providers to shift toward a practice of cultural humility and cultural safety.

Better integration of virtual visits: A recent report by the Government of Nova Scotia on the COVID-19 response[1] notes that from March 1 to December 31, 2020, 18.5% of physician billings were for virtual care, compared with 1% for the same period in 2019. For family physicians, virtual care accounted for two-thirds of total billings in this period in 2020. Physicians and patients acknowledged that pandemic-related restrictions likely were a factor. As well, while various videoconferencing platforms are available, only 1.4% of virtual visits took place by video. Telephone was preferred for most encounters.[1] Although the report suggests a need for evidence-informed guidelines on virtual encounters as an alternative to in-person care, I suggest we look at modes of contact broadly and holistically, guided by the clinical and relational patient-provider context, in a way that makes the most sense for patient, provider, and the health issue being considered. Support for organization of family practice (time, equipment, role of team members, etc) is needed for optimal integration of virtual visits.

Visibility in addressing access: Concerns are mounting regarding the risks to continuity of care as more private, for-profit businesses offer virtual visits. A recent survey of the public commissioned by the CFPC suggests patients prefer to see their own family doctors and are prepared to wait to do so—to a point. There are limits to waiting, and Canadians are prepared to seek care virtually from unfamiliar providers beyond a certain point. To achieve better access and continuity, governments must acknowledge the diversity and complexity of community-based care and support scaling up practice models, such as the CFPC's Patient's Medical Home, that are anchored in provision of a comprehensive basket of services by a team of providers, including family physicians, working collaboratively, responding to community needs. We must also recognize the emphasis our patients place on timely access and find ways to enhance that access. It is about working smarter, not more.

Approach to remuneration: Every remuneration model has pros and cons. Regardless of the model, we want to be patient-centred. Our health care systems, including remuneration of physicians, are more provider- and service-centred than patient-centred. Family practice is rewarding, but it is hard work; many of our patients have comorbidities and their issues are often complex. The fee-for-service system as the predominant remunerative model does not optimally address complexity. The time has come to broaden remuneration models available to family physicians. An ongoing evaluation should accompany this work.

Leaning in: As it relates to the organization of community-based care post pandemic, this requires us to be courageous, to accept a certain degree of vulnerability, to listen to ideas with humility, and to learn to live with the "messy middle," in order to get to better care.

The pandemic has taught us hard lessons. Now is the time to make the changes we want. Are we ready?

Acknowledgment

I thank **Eric Mang** for his review of this column.

Reference

1. Stylus Consulting. *Virtual care as a protective measure in Nova Scotia's COVID-19 response. The shift of physicians' services from face-to-face care.* Halifax, NS: Government of Nova Scotia; 2021.

Cet article se trouve aussi en français à la **page 631.**

Can Fam Physician 2021;67:632 (Eng), 631 (Fr). DOI: 10.46747/cfp.6708632