Moving the dial on team-based care in British Columbia

We explore three overarching questions related to team-based primary care in BC: Why do we need teams, where do we go next, and how do we get there?

Goldis Mitra, MD, CCFP, Thuy-Nga (Tia) Pham, MD, CCFP, FCFP, MSc, M. Ruth Lavergne, PhD, MSc

Nearly a quarter of adults across Canada do not have a family doctor, and the problem is even worse in British Columbia, at 27%.[1] Despite the introduction of the Longitudinal Family Physician Payment Model in BC and significant investments in primary care by the government over the last 2 years, attachment and access to primary care are still concerns for a significant portion of the population. This has substantial health care system impacts, as patients rely on emergency departments, walk-in clinics, and virtual care for access, and consultant specialists face the challenge of seeing patients without ongoing longitudinal follow-up.

The OurCare initiative is a national conversation about the future of primary care, focusing on the public's expectations, how the public defines good primary care, and the policy changes recommended to shape the system. Last year, OurCare published the results of a comprehensive initiative to understand the improvements Canadians want to see in our primary care system.[2] Over 16 months, from September 2022 to December 2023, the OurCare initiative engaged nearly 10 000 Canadian adults about their experiences with primary care and their values, ideas, and hopes for the future of family medicine. Through a national survey and subsequent deep dialogues with hundreds of residents across five provinces, the project aimed to understand how people engage with primary care and what areas need improvement. Participants were randomly selected to represent the geography and demographics of their province, with overweighting of specific equity-deserving groups.

The resulting recommendations were distilled into the OurCare Standard, a set of six elements that represent people's aspirations about what high-quality primary care should look like **[Box]**. One key takeaway was the first element of the standard: "Everyone has a relationship with a primary care clinician who works with other health professionals in a publicly funded team." Participants resoundingly felt that an integral part of the solution to the attachment and access crisis was to expand

BOX. The OurCare Standard.

1. Everyone has a relationship with a primary care clinician who works with other health professionals in a publicly funded team.
2. Everyone receives ongoing care from their primary care team and can access them in a timely way.
3. Everyone's primary care team is connected to community and social services that together support their physical, mental and social well-being.
4. Everyone can access their health record online and share it with their clinicians.
5. Everyone receives culturally safe care that meets their needs from clinicians that represent the diversity of the communities they serve.
6. Everyone receives care from a primary care system that is accountable to the communities it serves.

Dr Mitra is a longitudinal family physician and clinical assistant professor in the Department of Family Practice at the University of British Columbia. She is also on the executive team at BC Family Doctors and is the British Columbia physician lead for OurCare. Dr Pham is a longitudinal family physician and co-medical director of South Island Urgent and Primary Care Centres, Island Health. She is also an adjunct professor in the Department of Family and Community Medicine at the University of Toronto and a lecturer in the Department of Family Medicine at UBC. Dr Lavergne is a Tier 2 Canada Research Chair in Primary Care and associate professor in the Department of Family Medicine at Dalhousie University. She is also the Nova Scotia co-lead for OurCare.

Corresponding author: Dr Goldis Mitra, goldis.mitra@ubc.ca.

This article has been peer reviewed.

team-based primary care, both to increase capacity in the system and to address physician burnout. It is increasingly clear that robust teams in primary care are central to a high-functioning primary care system.[2]

Why do we need teams in primary care?

Declining capacity

We have a primary care capacity problem. Quite simply, we don't have enough family doctors to provide the increasingly complex care[4] that Canadians need to address their immediate medical issues and disease prevention. These health human resource problems are a global issue: there are significant shortages of doctors, nurses, and key professionals in both high- and low-income countries around the world.[5]

It is not feasible to train or recruit doctors fast enough to address this crisis, and it might not be the most efficient way to meet patients' changing needs. A family physician's training equips them to work in multiple areas of the health care system, where many also provide care for pregnant persons, work as hospitalists and emergency medicine doctors, and more. Because of the many areas in which family physicians work, we don't have enough of them to meet system needs. No matter how much we rearrange the deck chairs—for example, by convincing hospital-based family doctors to work in traditional family medicine offices—we still need net new capacity in the system today.

Increasing complexity

Practice patterns among doctors are changing: even in traditional family doctors' offices, physicians are seeing fewer patients than their predecessors.[6] This reflects the population aging and having more complex medical needs, but also the changing expectations of patients about care. It's not a matter of simply handing someone a prescription, telling them their diagnosis, and walking out of the room; shared decision making and ensuring a patient understands their diagnosis and treatment all take important face-to-face time.

At the same time, doctors are faced with a significant increase in the administrative complexity of care compared with 30 years ago—the tests and referrals that need to be ordered, the administrative avalanche of disability forms, Special Authority requests for medication coverage, and more.[4] All these tasks prevent doctors from seeing more patients face-to-face. We need models of care that are equipped to manage this complexity of care and the associated administrative work.

The potential solution to the primary care capacity problem isn't simply to add more health care workers to the already immense workforce. Solutions must make primary care more efficient and do away with some of the hurdles that take time away from seeing patients. Artificial intelligence scribes are already helping care providers write clinical notes,[7,8] and there is potential for much more capacity to be gained through improved use of technology.[9] We also need to reduce needless administrative work through electronic referral systems and better-connected electronic medical records,[10] and by doing away with mandatory sick notes.[11]

However, because the heart of family medicine is people connecting with other people, we *do* need to increase the number of providers doing this work while *also* recognizing and supporting its increased complexity. Robust, well-functioning teams can retain physicians in longitudinal practice, bring nonphysicians into the work of primary care, and make the delivery of complex care more efficient.

Where do we go next?

Effective teams

To ensure that all patients can access primary care when needed, capacity increases need to come from thoughtfully designed teams that include family physicians working alongside other clinicians. A team is not just a group of clinicians thrown together in a clinic or a sprawling network of professionals connected via cumbersome referral mechanisms.

The most effective teams in primary care[12] are organized around the common goal of providing accessible and continuous care to a defined panel of patients, working with common values from a shared playbook. A team isn't defined by who is included; it is defined by how effectively the participants work together.

One way to recruit family physicians is to create systems of shared care where doctors, nurse practitioners, and nurses care for a larger defined panel of patients as practice partners, making it possible to juggle work in other settings and time off. In this way, small clusters of health care providers (sometimes called teamlets[13]) who are trained in primary care best practices can come together and provide both increased capacity to care for patients and improved quality of care.

As an example, one of our authors shares a panel of 1300 patients with another physician; together, they provide care for their patients during the week. Each day, one doctor is responsible for the administrative avalanche and urgent patient issues, and they are supported by a medical office assistant who works directly with their team and patients. Each physician has a portion of the shared patients on their panel and is responsible for periodic comprehensive care reviews to ensure patient care is appropriate, up to date, and coordinated. A nurse employed through the local primary care network works part-time to support patients both in person and over the phone. On the days the author is not working in the office, they can work in other settings, such as the hospital. Their local division of family practice[14] has organized a community call group, so after 5 p.m. and on weekends, there is a local doctor that patients can call for urgent issues.

There are other models of team-based care to consider as well. Many doctors want to work in longitudinal family medicine but aren't ready to commit to a practice long-term. An all-hands-on-deck philosophy would support doctors who are interested in working in longitudinal family practice in whatever capacity they can. This

means clinic models are organized around providing a regular place of care for patients, such as a community health centre, even if the clinicians that patients see change over time. Many rural communities have advocated for this type of model, given their struggle to recruit and retain physicians. Importantly, skilled clinic-level leadership is required to provide this as a safe and viable option for physicians and patients.

If flexible options to work in longitudinal family medicine are not available, many physicians will opt to provide primary care services through virtual walk-in clinics. These clinics usually see a patient once online and then never again, which isn't the care most people want for themselves or their loved ones.

How do we get there from here?

Doctors sharing care, community call groups, and other systems that make longitudinal family medicine an attractive career don't occur by accident. They occur by design. In BC, our government, health system planners, and physician leaders are pivotal in helping shape the practice environment. This includes clearing the way for shared care of patients through remuneration that avoids disincentivizing shared care models, supporting mentorship of doctors who are considering shared practices, and coordinating community-based after-hours coverage.

A trained primary care workforce

Ninety percent of OurCare respondents said they would be comfortable receiving support from a team member their family physician recommended. Throughout BC, primary care nurses are successfully providing cancer screening, developmental screening for infants, cognitive testing for frail elders, and minor office procedures.[14] Nurses are currently funded in multiple ways, including fee-for-service compensation that funds direct hiring into clinics, primary care networks, and the Nurse in Practice program.[15]

Other invaluable team members in primary care include pharmacists, mental health clinicians, and social workers. In Victoria, family doctors can refer patients to community mental health clinicians and social workers directly through their electronic medical records system. In North Vancouver, when patients with depression or anxiety run into problems with their psychotropic medications, primary care network pharmacists provide in-depth consultations to help identify appropriate alternatives and manage medication side effects.

Doctors sharing care, community call groups, and other systems that make longitudinal family medicine an attractive career don't occur by accident. They occur by design.

A wide range of practitioners have the basic skills needed to be functional in any family practice, but they need specific training in primary care to help move the dial on our capacity problems. The training exists, but it is disconnected. Nationally, the College of Family Physicians of Canada's Team Primary Care initiative is working to standardize training for primary care nurses and implement a nationally accredited continuing education program. In BC, we need centrally developed and consistently delivered nurse training programs informed by physicians to ensure the training keeps up with the latest guidelines and evolving practices. We desperately need this work to move forward quickly.

Finally, we need investments in the workflow and technological changes required to improve efficiency so that offices can increase attachment and access. This expertise exists in BC, but it is inconsistently applied and is underfunded. Doctors of BC's business support program[16] is working to reduce administrative burdens for front-office staff and do away with Special Authority forms for family physicians and consultant specialists. The work needs to be better funded and supported to make it move quickly. The Family Practice Services Committee's Practice Support Program,[17] which helps doctors optimize their practices and better engage with health technologies, needs a significant reimagining of its work and impact, along with renewed investment, to ensure it meets the needs of physicians and the health care system.

Leadership for team-based care

Addressing the capacity and complexity crisis in our primary care system requires thoughtful policy change and legislative action to support the expansion of team-based care, allow more efficient use of technology to support care, and reduce administrative burdens that detract from patient-facing care. We can create a more sustainable and high-quality health system by building robust primary care teams and shared care structures, investing in standardized training and support for all team members and their clinics, and clearing barriers to shared care and collaboration. By working together, we can move toward a system where everyone has access and attachment to primary care and we meet patients' increasingly complex needs. ■

Acknowledgments

The authors thank Dr Tara Kiran for her support and guidance during the development of the article and Dr Tahmeena Ali for her valuable feedback and suggestions on earlier drafts.

Competing interests

The authors were involved with the OurCare initiative in various capacities.

Funding

OurCare is an initiative spearheaded by Dr Tara Kiran. Engagements in 2022–2023 were supported by Health Canada, the Max Bell Foundation, and Staples Canada. For a full list of collaborators, please visit www.ourcare.ca/about.

References

1. Kiran T, Daneshvarfard M, Wang R, et al. Public experiences and perspectives of primary care in Canada: Results from a cross-sectional survey. CMAJ 2024;196:E646-E656. https://doi.org/10.1503/cmaj.231372.
2. MAP Centre for Urban Health Solutions. Primary care needs OurCare: The final report of the largest pan-Canadian conversation about primary care. 2024. Accessed 25 November 2024. https://issuu.com/dfcm/docs/primary_care_needs_ourcare_the_final_report_of_the?fr=xKAE9_zU1NQ.
3. Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K. The 10 building blocks of high-performing primary care. Ann Fam Med 2014;12:166-171. https://doi.org/10.1370/afm.1616.
4. Lavergne R, Peterson S, Rudoler D, et al. Productivity decline or administrative avalanche? Examining factors that shape changing workloads in primary care. Healthc Policy 2023;19:114-129. https://doi.org/10.12927/hcpol.2023.27152.
5. World Health Organization. Health workforce. Accessed 24 November 2024. www.who.int/health-topics/health-workforce.
6. Rudoler D, Peterson S, Stock D, et al. Changes over time in patient visits and continuity of care among graduating cohorts of family physicians in 4 Canadian provinces. CMAJ 2022;194:48:E1639-E1646. https://doi.org/10.1503/cmaj.220439.
7. This Changed My Practice (TCMP) by UBC CPD. Talking smart: Conversational AI streamlines clinical practice. 14 February 2024. Accessed 24 November 2024. https://thischangedmypractice.com/conversational-ai-streamlines-clinical-practice.
8. Zafar A. Why family doctors across Canada are turning to AI scribes—and what it means for patients. CBC News. 23 November 2024. Accessed 24 November 2024. www.cbc.ca/news/health/ai-scribe-second-opinion-1.7390574.
9. Topol EJ. Deep medicine: How artificial intelligence can make healthcare human again. New York: Basic Books; 2019.
10. College of Family Physicians of Canada. Transforming the foundation of Canada's health care system: Solutions to bolster primary care. 2023. Accessed 24 November 2024. www.cfpc.ca/CFPC/media/Resources/Health-Policy/HPGR-FP-Reform-Policy-EN.pdf.
11. BC College of Family Physicians, BC Family Doctors. Sick note 2024. 2024. Accessed 24 November 2024. https://bcfamilydocs.ca/wp-content/uploads/2024/02/BCFD-BCCFP-Sick-Note-2024.pdf.
12. Bodenheimer T. Building powerful primary care teams. Mayo Clin Proc 2019;94:1135-1137. https://doi.org/10.1016/j.mayocp.2019.05.017.
13. Bodenheimer T, Willard-Grace R. Teamlets in primary care: Enhancing the patient and clinician experience. J Am Board Fam Med 2016;29:135-138. https://doi.org/10.3122/jabfm.2016.01.150176.
14. Reichert and Associates. Case study: Central Okanagan Division of Family Practice: Integrating nurses into practice: Transition stage. November 2020. Accessed 7 March 2025. www.jcc-resourcecatalogue.ca/media/divresources/CODFP_NiPCP_Case_Study_FinalReport.pdf.
15. Government of British Columbia. Nurse in practice program. Updated 15 February 2024. Accessed 14 January 2025. www2.gov.bc.ca/gov/content/health/nurse-in-practice-program.
16. Doctors of BC. Business support. Accessed 24 November 2024. www.doctorsofbc.ca/advice-support/business-support.
17. Family Practice Services Committee. Practice support program. Accessed 3 March 2025. https://fpscbc.ca/psp.