Physician Led Virtual Session - Summary of Panelist Q&A Topics

Description: In this webinar, family physicians in Vancouver discussed how they have adapted themselves and their clinics to phase 2 of COVID-19 to provide in-person care again. Time stamps for the video recording of the session (linked here) are indicated throughout this resource.

Date: June 9th, 2020
Host: Community Network Manager – Thilini Amaratunga
Moderators:

- Physician Support Team:
  - Community Network Managers – Tess Walton, Sara Johnson, & Stephanie Thomas
- Membership Committee:
  - Director, Membership Engagement and Collaboration – Justin Ho

Panelists:

1. Dr. Eric Cadesky @ The Doctors' Office
2. Dr. Daniel Dodek @ City View Medical Clinic
3. Dr. Panagiotis (Taki) Galanopoulos @ Blue Water Medical Clinic
4. Dr. Angela Lee @ Cross Roads Clinic

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Please note the following answers to the questions have been partially edited in this resource. For exact answers to the questions please see the corresponding recorded video of the session (linked here).

[14:15] **Theme 1: Business Continuity and Finance**

[14:30] **Question 1: How has your business been impacted by COVID-19?**

Cadesky:

- We haven't had to actually furlough or fire anyone. We have had some staff that weren't originally from Vancouver that wanted to go back to their home province before some of the provincial borders closed up. What we mostly did was borrow from our future.
- As soon as the telehealth fees became available, we pulled data from our EMR and we started contacting the most vulnerable patients because (1) it's good care to make sure they knew we were available for them, and (2) it kept us afloat to have some of those modifiers. Normally, we would have these billings to help prop us up towards the end of the year, but we aren't going to have that this year.
- On the flip side - by not going into immediate peril we weren't eligible for many of the provincial and federal programs to help keep businesses afloat.
- We've ended up putting more against our future in order to stay afloat, to keep our doors open, and to keep our physicians engaged and our staff employed.

Galanopoulos:

- The phone call parity really helped us. We also saw an increase in the number of patient appointments (due to telehealth).
- We have student learners in our clinic and once we figured out how to precept in the virtual environment, it was helpful to have the extra 10 people you need to make telehealth work.
- I didn't stop doing house calls to the assisted living facilities (ALFs). We initially tried to do some kind of telehealth, but it wasn't working. This population is the most vulnerable. Many doctors, rightfully because of their age, etc., stopped seeing patients at the ALFs. So in addition to my own patients, I was seeing other physician's patients as well.
- The hardest thing we had to do was find PPE. It is very scary to call suppliers and have them tell you "we don't have any PPE" when you're trying to run a business. The Division was very helpful. Going forward, we as family physicians need to find a way to collectively protect ourselves.
- I was also lucky that our business model has a VOIP phone system so that my providers can download an app and pretend that they're at work when they're at home and use our web-based EMR. We were lucky that InputHealth worked seamlessly.

Lee:

- These challenges were immediate for us and most were unforeseeable and affected every single aspect of the clinical operations which subsequently had these severe financial consequences to our clinic as a whole. I broke down my clinic into 5 sectors and made a chart.
    - These sectors were:
    1. Physical parts of the clinic: The exam rooms, waiting rooms, the lack of PPE supplies, physical barriers (plexiglas)
    2. IT: Hardware, software, EMR adaptations, 3rd party apps
    3. Staff: Rewriting existing workflow, in the beginning decreasing staff because of decreased business but now having to increase staff and increase hours and pay for increased staffing to adapt to increasing in-person visits
    4. Physician: Implementing workflow changes to allow remote access. Our EMR is not web-based and doesn't have a built-in telehealth platform.
    5. Patient: How to deliver adequate care and how to disseminate this information and notify patients of these changes.

- Not only have every single sector and sub-sector been impacted, they've required additional financial commitments to adapt during this pandemic. We need to change to not lose money, but it also costs money to change. Time wasn't on our side, so it was extremely challenging.

[21:40] **Question 2: What professional consultation and financial supports have been utilized to address a business liability?**

Cadesky:

- Colleagues – especially the Division; Thank you for the daily emails.
- DoBC has been great. We are taking in information as it comes. For example, we all breathed a sigh of relief when we thought we were going to get hazard pay – $4 per hour that was announced for frontline staff. We thought this was for all of our staff as well, then realized they actually don't qualify for this.
- We've been doing our best to rely on professionals, peers, professional organizations, and associations.

Galanopoulos:

- I was dealing with my banks and with any heavy equipment suppliers - I had to try and get whatever deals they could offer me. I would save a thousand dollars here and a thousand dollars there and that was the difference between making rent or not. It was a very stressful 4-6 weeks to try to find out who could help me and how.
- Since I have the aesthetics practice, I didn't dip like the government said you had to dip for to get some of that financial help. So I wasn't able to get the help that some of the other practices were receiving. I understand you have to make rules for how you can help the most people, but it was frustrating.
- I qualified for that $40,000 loan with the possible forgiveness of $10,000. This helped with payroll for the second and third run and some of the other increasing costs. My bankers and accountants were all in it with us. I felt like they had all of our best interest at heart because they were suffering too.

Lee:

- I have 3 words to describe trying to navigate the federal and provincial financial support - difficult, disappointing, discouraging.
- My business partner has an accounting degree - he would regularly tell us we don't qualify for this or that because we didn't dip. This was tough because we had to work really hard to make the rent! So we didn't qualify for the rent subsidy. We felt really left out and frustrated.

[25:50] **Question 3: Where do you see your clinic in a years' time? Has this changed since your clinic has adapted for the pandemic?**

Cadesky:

- I hope we are still open. It is really tough as my colleagues have pointed out. Trying to come up with a business plan is something that we have the GPSC for. The last 2 physician master agreements where we basically come up with a huge structure, it has hundreds of millions of dollars. It has one focus which is to keep community-based practices alive. That's what we were trying to do before the global pandemic and now we have seen the stresses that we have talked about.
- Despite the fact that we've reached out and been proactive in reaching out to our patients, despite the fact that there are numerous ad campaigns telling people your doctor is open... people still feel very shy about it.

- I know this because I still get notes from Babylon from my patients who could have easily contacted me. I think what we are seeing is the pressure of patients feeling guilty and not coming to see us when it is actually the opposite. We want them to stay in touch both for their health as well as for ours.
- We are experiencing pressure with the MOAs. Traditionally it would be difficult to compete with health authorities who offer bigger contracts, and better benefits. Now with things like the $4 in hazard pay it's another thing for us to overcome to get people to stay in the community as opposed to moving into facilities.
- In terms of physicians, it's been very similar where hospitalist work has traditionally paid a lot more than working in a community-based practice. Now we have the UPCCs that are opening up and proliferating and I know that the Division has been very vocal about saying these sorts of enterprises should be complementary to what we are doing but we see in other communities where they've poached physicians and if I were an early career doctor coming out with high 6-figure debt, it makes sense, your heart might not be in it, but the heart and soul don't put food on the table and don't pay for the roof over my head. I don't blame doctors at the early, middle and end parts of their career that want to go into good work and also follow what is going to be best for them personally.
- We're doing our best to say to colleagues that community clinics are where you can be autonomous, this is where you can do the kind of medicine that you want to do. There's only so much I can keep saying to my colleagues... hold on there's some contracts that should be coming, trust me there's work going on behind the scenes... hope only holds out for so long. This has been such a stress that all we really have to bank on is each other and collegiality and that good intentions must come through at the end.

Galanopoulos:

- The interesting part for me is that the old idea of having 1 physician in 2 rooms is done. I am happy about that as a clinic owner. Now I might be able to hire more physicians because 1 physician only needs 1 day per week in the clinic. Now instead of only 5 providers my clinic may be able to grow to 6 or 7. From an overhead perspective, I might be able to make it.
- If they take away the parity of phone calls to regular telemedicine visits, that is definitely going to hurt us right now because the bulk of my practice is more older/retiring patients. That has helped me from the FFS model so far has been that parity – once that goes away I know that my finances will dip. I have to borrow from the future so instead of doing my chronic care bonus visits in August, I had to pile as many as I could in the beginning of the pandemic to try to put some money in the till.
- I hope to see group purchasing soon. I felt like I was a nobody, when I was trying to talk to vendors before. I wondered if we could join physician group purchasing that could actually get better deals.

Lee:

- I don't see much that we would change in a year, unless we have a vaccine and a cure.
- How can I continue to provide leadership if all of my colleagues and staff are continuing to hold on and wait for this? They are going to get discouraged. It's hard to promise something and have it not go through.
- I think there is strength in numbers, and I think primary care physicians need to work together towards what that is going to look like in a years' time and how it's going to benefit us as clinic owners and primary care physicians.

[33:35] **Theme 2: WSBC Plan and Clinical Operations**

[33:50] **Question 1: How have you adapted your clinics operations to provide in clinic services?**

Cadesky:

- The things that have gone well for us have been complete luck. There were a number of things that allowed us to pivot quickly:
    1. We are lucky enough to have some of our staff be germaphobes before that was cool and so we've had plexiglass since before it became the new toilet paper.
    2. Also, with the type of practice that we have, all of the doctors do something other than just in-office family practice. We always had a lot of people who were mobile and so we used telephone fees, we had different video conferencing platforms set up already. It was just a matter of onboarding more of our doctors onto it.
    3. I have been using efax for ages because I think the fact that we have so much paper in the office despite the EMR is absolutely absurd.
- Since the pandemic started, We have been telling our patients we don't want you to come in, you shouldn't want to come in. However we have a number of patients that have conditions for which they had to come in whether it was allergy desensitization, vaccinations, etc.
- We had weekly virtual meetings to decide as a group, including the staff, what we are comfortable with having people come in for. Every in-person visit has already been triaged and already been vetted early on.
- We did have to make the decision to not to see patients with respiratory symptoms – as it was a tremendous source of stress for our staff. When we realized that we weren't going to have enough swabs, we had to think about the cost in terms of being able to clear a room, etc. Financially, we couldn't do things like swabs and keep our clinic afloat.

Dodek:

- This process has been hard and stressful, but it really has been about teamwork with our colleagues, MOAs and office managers. We have had to adapt daily and weekly to change what our goals are. We have had to focus on safety with each decision. Changes that we made include:
    - Discontinued the walk-in service at our office immediately.
    - Discontinued online booking for patients so they could no longer book their own appointments.
    - Updated our phone message and our phone triage.
    - Implemented signage everywhere in the office re: safety procedures and social distancing (entrance, exam rooms, hallways, bathrooms). We had to clear up books, toys, and reduce the chairs in the exam room to ensure they are an appropriate distance apart.
    - Office staff directs patients to show up by themselves with no family members.
    - Implemented plexiglass at the front, hand sanitizer and the front, and offer every patient a mask if they're not wearing one.
    - Each exam room has 1 chair only which helps with the cleaning process to be efficient. We clean each exam room and organize it to have minimal touch spaces.
    - No one is allowed to make an in-office appointment unless it has been cleared by the attending doctor.
- Pre-pandemic, we would have 5 doctors working at once - each doctor would have 2 exam rooms and would see an average of 5-6 patients per hour in office. Beginning of the pandemic

we reduced our clinics to 2 doctors in the office, seeing on average 2-3 patients per hour. Obstetric doctors were the main physicians doing in-patient services. Phase 2 involved a lot of negotiations and teamwork. We now have 3 doctors in the office seeing a maximum of 3 patients per hour (started this week). This involved negotiations and organization with everyone.

Galanopoulos:

- As soon as anyone walks in, we have hand sanitizer, gloves, masks, we take their temperature, we do COVID questionnaires. We have a UV-sterilizer for cell phones as a courtesy (takes 6 mins).
- I couldn't afford the Plexiglass - the quotes were too high so if anyone is looking... Staples has hanging sheets for about $200 a peice so I bought 2-3 for less than $1000.
- In the waiting room, we put chairs in the front of the reception desk as a physical barrier to protect the staff for now.
- We limit no more than 3 patients for the whole clinic per hour – it has worked well this week. Our patients have allowed us to do more virtual and telephone visits with them so we're going to do that as long as we can.
- Our PPE stash has a physical barrier in front of it so no one can see it/steal it. My janitorial service has EnviroShield which is a coating that decreases the viral load on objects. We took that extra cost. Staff has been wonderful with communicating with patients when and if they can come in and the process.

Lee:

- I divided my clinic into sectors and went through it according to the WSBC safety plan. Prioritized which changes were urgent and mandatory, and which ones I could afford. There were workflow items that couldn't be addressed because our financial situation was not stable.
- We went with tempered glass for our clinic – it cost us $400 more than plexiglass.
- Teamwork was important. My staff who was willing to take decreased hours and now willing to take increased hours to implement the WSBC safety plan. My physicians who worked well together and gave shifts up for each other to physicians who needed it more.

[49:18] **Question 2: What role has your office staff played in reopening your clinic?**

Cadesky:

- They've been central. They are the front line of the front line.
- Our staff were triaging patients as they came in - even before people stepped into the clinic. We had big signs and there will be consequences for breaking these rules. People would stand outside and call us on their cellphones.
- Our staff is always our eyes and ears and we have always relied on that.We haven't had any attrition, but we also haven't had any of those difficult conversations about money. Asking staff their opinion was a part of our clinical and business continuity plan.

Dodek:

- We have two office managers - One in charge of billing, the other in charge of supplies, scheduling and equipment. This has been central in tracking how much PPE we go through and making sure we have appropriate supplies in the office.
- Our MOAs have really come together in terms of keeping it a safe and healthy workplace for everyone. At the beginning there were a lot of unanswered questions and fear but now people have gotten into the routine and MOAs are feeling more confident. They are thriving in a difficult situation.

Galanopoulos:

- Open communication. We have thought hard how to safely do what we want to do and protect ourselves. My staff has been wonderful. We have a Friday huddle where we discuss what's working and what isn't and where we can improve.

Lee:

- The best thing that we implemented was a facility-wide greeter. This required creating a full-time position with new responsibilities. This was only possible because the other clinics were contributing financially to this. One of my MOA's would be the greeter every morning (5 hour shift). They would take turns and would put on their PPE. They would take patients' temperature and vet these patients for all of the clinics.

[55:36] **Theme 3: Clinical Workflow & Specific Procedures**

[55:40] **Question 1: What in-person services have you decided to provide during the pandemic or reintroduce?**

Dodek:

- I have a lot of elderly patients in my practice and they are fearful to come into the office – some of them haven't stepped out of their homes. I have tried to manage heart failure over the phone, which is a challenge, but after some time I've had these patients come in to do a clinical exam.
- Other things we have not been able to deal with over the phone include, breast lumps, pap recalls, vaccinations, prenatal care, post-natal care and post-surgery care.

Galanopoulos:

- Mothers who have just given birth were given priority to see their baby first in-person and to ease their questions. We don't offer vaccines. Only when there has been an abnormal pap-smear we bring them in a bit earlier.
- I've really left it in the hands of the provider. I have continued assisted living services for now. My providers are very comfortable with handling what they think is safe.

Lee:

- We have introduced all in-patient visits that cannot be done virtually, with an exception of infectious or COVID resembling symptoms – in this case we have a whole different process that starts with a virtual visit.
- I leave it up to the provider for what they bring into the clinic after they've vetted the patients.
- Our waiting room is designed with social distancing. No more than 9 patients can be in our waiting room and that includes the other clinics that share the space.
- In-patient visits are booked ahead of time, they are screened by the MOA when booked. Upon arrival the patient is screened by the greeter. The patient is then immediately directed into the exam room or waits for a short time. We limit how many patients can be seen and are allowed in our waiting room.

Cadesky:

- We don't necessarily see it as they are coming in for an in-person visit. We see it as they are coming in for an in-person procedure.
- Medical history is discussed before visit (virtual care)⟶ In-patient visit - for procedure only⟶ Patient goes back to their car to discuss further (virtual care).

[1:03:42] **Question 2: Are there any specific procedures that you no longer feel that you are able to or feel comfortable carrying out?**

Dodek:

- Our office doesn't have the capacity to provide in-person care for chronic, stable medical conditions due to the space, timing, and the cleaning. All these types of chronic medical conditions (~80% of my practice) are ones that we will not be providing in person.
- Decision: When do we start calling patients for their routine pap test? For myself, I don't have the capacity right now for individual procedures so that is on hold. My Monday mornings are reserved for urgent physical exams. In 3 months, I might have a different discussion.

Galanopoulos:

- I think it will be finance-dependent. I will only do as much as my PPE will allow - it's been tough getting PPE. The remuneration - certain things will no longer be attractive to do in the office.
- Safety is also another issue. We have agreed as providers, as long as you feel safe about doing the procedure it is okay to do so.

Lee:

- We do not do COVID assessments. We have other clinics that would feel extremely nervous if we started doing that in our clinic."

Cadesky:

- Nothing that generates aerosols, we aren't bagging/masking anyone, or doing bronchoscopies.
- We are screening people. If we start screening people with respiratory issues, we would not be able to treat as many patients as we do - thankfully, we have UPCC's do those screenings.

[1:07:50] **Theme 4: Communications**

[1:08:20] **Question 1: How have you communicated your WSBC safety plan or expansion of services to your patients and staff?**

Cadesky:

- We have worked with our EMR vendor to push out mass emails to our patients, updated our website, updated our phone tree, and we have signs everywhere.

Dodek:

- Our staff goes through a weekly huddle that I lead, we try to do this in a supportive environment. We promote questions, discussions around their challenges, questions they are receiving, workload, cleaning demands, etc. Email blasts, updating websites.
- We have an RN at our clinic that has reached out to a lot of our frail elderly to update them individually and check-in.

Galanopoulos:

- We changed our phone tree a little bit. We haven't done the email blasts. People are mainly calling in. We have the rapid scanner and the VOIP phones and 2 monitors. If I could've done it again, I would have tried to change our website – we had some issues with the developer.

Lee:

- The WSBC safety plan is completed, - it's posted in the clinic and networked into the computers. We have changed our website, telephone greeting tree, we have regular staff meetings, we rewrote the MOA handbook, we have a separate Whatsapp group for the MOAs, the FPs, and the specialists. We enlisted the help of a digital health platform called Care Team - Helped to facilitate patient communication and workflow adaptations. We are still able to work off of that now. If I had to do this again, I would've probably collected emails a lot more seriously.