

DOCTORS NOVA SCOTIA
2017 Position Paper

FIXING NOVA SCOTIA'S PRIMARY HEALTH CARE PROBLEM:

**PHYSICIANS' RECOMMENDATIONS
TO IMPROVE PRIMARY CARE IN
NOVA SCOTIA**

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ACKNOWLEDGMENTS

Thank you to the members of the Doctors Nova Scotia Policy and Health Issues Committee (PHIC), General Practitioner (GP) Council and Board of Directors, who provided the concepts for this document.

PHIC members – Drs. Melanie Adams, Monika Dutt, Gary Ernest (chair), Leo Fares, Alyson Holland, Tim Holland, Tammy Keough-Ryan, Rod McGory, Elwood McMullin, Maria Migas, David Milne, Sanju Mishra, Leslie Ribeiro, John Sullivan, Manoj Vohra and Howard Wightman

GP Council members – Drs. Peter Brennan, Michel Chiasson, Alban Comeau (chair), Alana Cormier, Gary Ernest, John Ginn, Mary Gorman, Ajantha Jayabarathan, Stephanie Langley, Erica Lasher, Patty Menard, Mary Frances Moriarty, Barb O'Neil, Colette Sauveur and Ehab Soliman

Board of Directors – Drs. Minoli Amit, André Bernard (Board Chair), Michelle Dow (President), Kathy Gallagher, John Ginn, Tim Holland, Todd Howlett, Heather Johnson, Robyn MacQuarrie, Scott Mawdsley, David Milne (Past-President), Alex Mitchell, Norah Mogan, John Murdoch, Manoj Vohra (President-Elect), Mike Wadden and Celina White, and medical student Matthew Lowe

A special thank you to the following physician leaders, who provided ongoing counsel during the development of this position paper:

Dr. Melanie Adams, Glace Bay
Dr. Lisa M. Bonang, Musquodoboit
Dr. Fred Burge, Halifax
Dr. Jeff Colp, Prospect
Dr. Esther Dias, Glace Bay
Dr. Michelle Dow, Meteghan
Dr. Michael J. Fleming, Fall River
Dr. Gary Ernest, Liverpool
Dr. Zaida Fragoso-Alvarez, Lower Sackville
Dr. Timothy Holland, Dartmouth
Dr. Ajantha Jayabarathan, Halifax
Dr. Tammy Keough-Ryan, Halifax
Dr. Stephanie Langley, North Sydney
Dr. Shelagh Leahey, Yarmouth
Dr. James MacKillop, Sydney
Dr. Tim Matheson, Bedford
Dr. Mary Frances Moriarty, Dartmouth
Dr. Katherine Quackenbush, Upper Tantallon
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FIXING NOVA SCOTIA'S PRIMARY HEALTH CARE PROBLEM: PHYSICIANS' RECOMMENDATIONS TO IMPROVE PRIMARY CARE IN NOVA SCOTIA

EXECUTIVE SUMMARY

Doctors Nova Scotia (DNS) engaged family physicians throughout the province to develop a position paper on primary care. As the association representing all physicians, residents and medical students in the province, we know that there is not a one-size-fits-all approach to providing primary care. We also know how important it is that every Nova Scotian has access to a family physician, most often (but not exclusively) as part of a collaborative primary health care team. Having access to primary care is an important way to improve the health of Nova Scotians, manage chronic diseases and create a more sustainable health-care system. Creating an environment where all Nova Scotians have access to primary care will require our health-care system to evolve. Primary care teams will need to be developed and organized differently, and the way physicians practise and are compensated will need to change. Family physicians understand and support the need for change, and want to be part of reforming the primary care system.

Based on the feedback provided by family physicians, the Policy and Health Issues Committee (PHIC) and the General Practitioners (GP) Council, as well as a study of literature and primary care models in other provinces, DNS makes the following recommendations to improve primary care in Nova Scotia immediately.

- We recommend that physicians be given the opportunity to choose what type of practice they want to work in and develop.
- We recommend that the Department of Health and Wellness (DHW) and the Nova Scotia Health Authority (NSHA) implement patient rostering as part of a new payment model for primary care.
- We recommend that the DHW and NSHA work with DNS to develop a new blended-payment model to better support patient care, fair compensation and good stewardship of public funds.
- We recommend the DHW ensure that compensation is not a disincentive for physicians to provide non-face-to-face services, and that physicians leverage opportunities to provide non-face-to-face services in their practices.
 - We recommend that the DHW and NSHA support family physicians in implementing same-day/next-day access in their practices, and that physicians use this support to improve access for their patients where appropriate.
- We recommend that the DHW, NSHA, physician recruiters and Dalhousie Medical School work with DNS to develop a recruitment and retention strategy.
- We recommend the DHW, NSHA, physicians and other providers develop creative and flexible solutions that produce timely results for patients.
- We recommend that walk-in clinics be maintained during the transition to a better primary health-care system.
- We recommend that alternative payment plans (APPs) be maintained during the transition to a new primary health care system with opportunities to evolve to a blended payment model mechanism.
- We recommend the DHW, NSHA and IWK prioritize and invest in the development of a secure electronic health record that is accessible by all health-care providers.
- We recommend that the DHW, the NSHA and the IWK engage physicians in transforming the primary care system in Nova Scotia.

➤ WE RECOMMEND THE **DHW ENSURE THAT COMPENSATION IS NOT A DISINCENTIVE FOR PHYSICIANS** TO PROVIDE NON-FACE-TO-FACE SERVICES, AND THAT PHYSICIANS LEVERAGE OPPORTUNITIES TO PROVIDE NON-FACE-TO-FACE SERVICES IN THEIR PRACTICES



**DR. HOLLY ZWICKER
TANTALLON**

"We try to see our patients as much as possible," says Dr. Zwicker. She and her colleagues use online booking software, an EMR and the services of a family practice nurse to ensure their patients have same-day/next-day access to primary care.

INTRODUCTION

Primary health care is the backbone of Nova Scotia's health-care system. Primary health care is the first place people go for health-care or wellness advice and programs, treatment of a health issue or injury, or diagnosis and management of a health condition. It is the foundation of any health-care system, and nations with strong primary health care have better health than those without (University of Ottawa, 2016). Countries with a strong primary care orientation have demonstrably better health outcomes, lower mortality rates and lower overall health-care costs (Aggarwal, 2012). Primary care also improves and sustains the health-care system at other levels. Primary care providers, as the "gatekeepers of health-care delivery," can reduce unnecessary costs and the need for specialty care by improving the quality of prevention, coordination and continuity of care (Canadian Health Services Research Foundation, 2012). Yet Canada's performance in primary care trails that of many other high-income countries, and Nova Scotia lags behind many Canadian provinces (Aggarwal, 2012).

A high-functioning and efficient primary health care system will ensure Nova Scotians can access primary care when they need it.

It is not possible or feasible for every service to be available in every community; however, every Nova Scotian should be able to access a primary health care team that includes a family physician. Today, this is not the case in our province.

In order for every Nova Scotian to have access to a family doctor, the primary health care system needs to be restructured. Attempts have been made in the past to improve access to services, but barriers to providing the best possible care to patients remain. These barriers are frustrating for Nova Scotians, physicians and the provincial government. Nova Scotia has made some improvements in primary care, such as the introduction of Collaborative Emergency Centres, investments in a small number of collaborative care teams, and the creation of residency teaching sites, which aim to train more family physicians in rural medicine, in South West Nova, the Annapolis Valley and Sydney. Yet our province continues to fall behind in many areas. For example, provinces such as New Brunswick, Quebec, Manitoba, Alberta and British Columbia have developed programs and structures to support the advancement of primary health care and collaborative care, while many Nova Scotians

are unable to find a family physician and face long wait times for services, and physicians in the province are dealing with recruitment and retention challenges and a fractured electronic medical record (EMR) environment.

The physicians of Nova Scotia, through DNS, want to improve the primary health care system in the province. Physicians know the biggest barriers to effective and accessible primary care, and how these barriers are affecting Nova Scotians. Physicians are essential to the success of transforming the health care system,

as are innovation, creativity, the courage to try new things and the wisdom to accept lessons learned in other jurisdictions. This paper outlines the principles that the physicians of Nova Scotia believe must guide primary care reform, while being mindful of each of these keys to success, as well as the barriers and opportunities we foresee. This paper also includes a proposal for a payment model to support high-functioning primary health care teams.

BACKGROUND

Having access to a family doctor is a critical component of a primary care system. Unfortunately, many Nova Scotians are unable to find a family doctor. While Nova Scotia has the highest physician-to-patient ratio in the country, with 260 physicians per 100,000 people (Canadian Medical Association, 2014); the distribution (by specialty and geography) of these physicians remains unbalanced in the province. The high physician-to-patient ratio can be attributed in part to the facts that Nova Scotia provides tertiary care to people from all of the Atlantic provinces, and that Dalhousie Medical School is the largest medical education site in the Maritimes. Even

with a high physician-to-patient ratio, there are still approximately 90,000 Nova Scotians without a family doctor (Statistics Canada, 2014). The provincial government physician resource plan identifies the need to recruit 512 full-time equivalent (FTE) family physicians over the next 10 years. Of those, 465 FTEs are to replace existing

practising family physicians and 47 are new family physicians needed to address increased patient need (Nova Scotia Department of Health and Wellness, 2016).

Those without a family doctor have been left feeling frustrated and uneasy about the level of care they are receiving. Although they

often access primary care through walk-in clinics and emergency departments, these patients do not have access to one provider who knows their medical history. Patients receiving episodic care through walk-in clinics and emergency department visits do not have access to the comprehensive care that many of them need to manage their health. In addition, those who do have a family physician often struggle to see their doctor in a reasonable period of time; some patients need to wait several days to see their family doctor when they are ill. In many cases, even patients with family physicians end up accessing care in a walk-in clinic or emergency department.

Patients continually express their concerns with their level of access to primary care services in Nova Scotia. These concerns are shared by family physicians throughout the province. Nova Scotia has an aging population, and many individuals are living with chronic diseases and multiple morbidities. This is straining not only primary health care but the province's emergency departments, in-hospital care and long-term care systems. As the first stop for patients when they are ill, family physicians are being asked to provide more services in their practices, including palliative care, mental health services, chronic plan management, pediatric care and geriatric care, accessing specialist care as appropriate. This helps alleviate strain in other areas of the

➤ THE PROVINCIAL GOVERNMENT
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system, but continues to overburden primary health care providers. Although it is appropriate for family physicians to provide these types of care, it can be challenging for them to do so without the proper supports. When family physicians are providing more complex care

in their practices, they end up taking on more work with fewer resources, which results in longer wait times and shorter appointments for patients, and increased workloads for primary health-care providers.

CRITICAL SUCCESS FACTORS

NOVA SCOTIA PHYSICIAN PERSPECTIVES

Nova Scotian physicians, including members of the association's PHIC and GP Council, have identified critical factors that are essential to the success of an effective primary health-care system. These factors build upon the work done by other organizations and jurisdictions.

These critical success factors are:

- Every Nova Scotian must have access to a primary health care team that includes a family doctor. This is important for patients and for the sustainability of the system. Better access and greater attachment to a family physician lead to better health outcomes, which in turn reduce cost by

reducing hospitalizations, re-admission rates, unnecessary diagnostic tests, professional visits and emergency department

use (and, indirectly, by increasing employment, productivity and economic growth).

- The unique doctor-patient relationship should be respected.
- Family physicians must not only treat illness, but also work with their patients and communities to prevent diseases. Family physicians want to play a role not only in treating illness but also in preventing it.
- Patients must be engaged in defining what effective primary care is.
- Primary care should be patient-centred, provide continuity of care, and be efficient and effective. Patients should have access

to multi-disciplinary teams/resources.

- In order for primary care to be effective, all system stakeholders – including patients and communities; the DHW, NSHA and IWK; and stakeholder groups such as DNS – must work well together.
- Not all communities will need the same type of primary care providers and services; however, every community does require access to primary care. System planning must take community needs and gaps in services into account.
- When responding to community needs, family physicians should be able to commit to one or more clinical areas as major components of their practice to best serve their patient population.
- The concepts outlined by the College of Family Physicians of Canada (CFPC) in their “Patient’s Medical Home” (PMH) should be a starting point for restructuring primary health care. The concepts include:
 - o Providing patient-centred care
 - o Ensuring every patient has a personal family physician
 - o Providing a broad scope of services carried out by teams or networks of providers
 - o Increasing timely access
 - o Improving continuity of care, relationships and information for patients
 - o Maintaining EMRs for patients
 - o Training medical students, family medicine residents and those in

➤ EVERY NOVA SCOTIAN MUST HAVE ACCESS TO A PRIMARY HEALTH CARE TEAM THAT **INCLUDES A FAMILY DOCTOR.**

- o other health professions
- o Evaluating the PMH's effectiveness in continuous quality improvements
- o Working within governance and management structures defined by stakeholders such as government, patients, the public, and other medical and health professions and their organizations across Canada
- Team-based care should be supported. It enhances patient care, increases professional satisfaction for physicians, helps recruit and retain new medical graduates, and provides more opportunities for ongoing professional development among health-care providers.
- Physician recruitment and retention should be a priority. Policies, payments and actions should reflect an awareness of the need for more family physicians in the province.

PRIMARY CARE CHALLENGES

Primary care reform must be undertaken with these critical success factors as guiding principles. One key element is to move to more team-based care. Team-based care offers many potential advantages, “including expanded access to care (more hours of coverage, shorter wait times) [and] more effective and efficient delivery of additional services that are essential to providing high-quality care, such as patient education, behavioral health, self-management support, and care coordination” (Schottenfeld, 2016, p. 3).

There is a growing body of Canadian research that demonstrates the value of collaborative primary health care. For example, in 2014 the Association of Family Health Teams of Ontario released an external evaluation report on family health teams (FHT) that demonstrated improvements over the study period in the areas of access to same-day appointments and chronic disease management (Conference Board of Canada, 2014). Other reports,

such as the *Evaluation of the Full Service Family Practice Incentive Program and the Practice Support Program* (Hollander, 2013), have also identified promising findings for

team-based primary care.

However, moving toward more team-based care is not without challenges.

PAYMENT STRUCTURE BARRIERS

The way physicians are compensated can be a barrier to providing patient-centred care in a collaborative environment. Doctors in Nova Scotia are currently paid primarily under three models: fee-for-service (FFS), alternative payment plans (APP) and academic funding plans (AFP); in addition, a limited number of physicians working in Collaborative Emergency Centers (CECs) have unique payment structures. Although each of these models works for certain practice environments – solo practice, under-served areas or a teaching environment, for example – they do not always support collaboration between care providers.

Under the FFS payment model, doctors are usually compensated for the number of services they provide, not the length of time they spend with patients or collaborating with other health-care providers, such as nurses or pharmacists. Doctors are independent contractors responsible for paying their staff and overhead costs (such as rent and office equipment). Physicians need to be able

➤ UNDER THE FFS PAYMENT MODEL, **DOCTORS ARE USUALLY COMPENSATED FOR THE NUMBER OF SERVICES THEY PROVIDE, NOT THE LENGTH OF TIME THEY SPEND WITH PATIENTS** OR COLLABORATING WITH OTHER HEALTH-CARE PROVIDERS, SUCH AS NURSES OR PHARMACISTS

to work enough hours to cover their staff's salaries, their practice-related expenses and their own salary. It can be challenging for them to make unpaid time available to collaborate with other providers.

Additionally, as other health-care providers are expanding their scopes of practice and providing more services to patients, family physicians are more seeing patients with complex conditions in their offices and fewer patients for short visits for preventative medicine, such as immunizations. It is appropriate for family physicians to provide complex care and for other providers to work to their full scope of practice. However, the system must compensate doctors for spending more time with patients when that is needed and for coordinating

patient care with other providers, rather than financially penalizing them for seeing fewer patients in a day. As we learn more about the best ways to provide care to patients and communities, it is important that the compensation models for family physicians also evolve.

Nova Scotian doctors have identified the need to shift compensation to mechanisms that better support preventative medicine and chronic disease management. Over the past two decades this shift has occurred in other provinces, where different payment models have been developed to support collaborative models of care. Nova Scotia's funding models must evolve to support more effective primary care delivery.

ELECTRONIC MEDICAL RECORDS

Electronic medical records (EMRs) are the backbone of primary health care and collaborative care teams. Approximately 60 percent of family physicians in the province use an EMR. However, Nova Scotia does not have an effective way to share medical records among health-care providers, hospitals and medical zones. The current hospital-based systems are poorly integrated and, in some cases, outdated. This is a major obstacle the province needs to overcome before it can significantly improve how primary care is delivered.

The provincial government has tried to improve e-health systems in Nova Scotia. One of the most recent efforts is One Patient One Record (OPOR). OPOR is intended to improve patient care and safety by providing clinicians with a single, province-wide electronic medical

information system for health system use and direct patient care. The project has been delayed but now appears to be moving forward.

The province also moved forward with MyHealthNS, a secure system that allows Nova Scotians to receive, view and manage their personal health information online. MyHealthNS is an important step toward a less fractured e-health system; however, it does not replace a system that shares electronic health records among providers. The lack of integration within the province is causing significant challenges for improving collaborative care. A system that allows one secure electronic health record to be accessed by care providers as appropriate would improve care, reduce unnecessary testing, improve patient safety and increase system efficiency.

➤ THE LACK OF INTEGRATION WITHIN THE PROVINCE IS CAUSING SIGNIFICANT CHALLENGES FOR IMPROVING COLLABORATIVE CARE.

A SYSTEM THAT ALLOWS ONE SECURE ELECTRONIC HEALTH RECORD TO BE ACCESSED BY CARE PROVIDERS AS APPROPRIATE WOULD IMPROVE CARE, REDUCE UNNECESSARY TESTING, IMPROVE PATIENT SAFETY AND INCREASE SYSTEM EFFICIENCY

PRIMARY CARE RECOMMENDATIONS

TRANSITIONING SAFELY TO A BETTER PRIMARY HEALTH CARE SYSTEM NEW INITIATIVES THAT NEED TO BE IMPLEMENTED

Nova Scotia is lagging behind other provinces in advancing primary health care reform. For example, in 2015 British Columbia released its vision for primary care in the document *Primary and Community Care in BC: A Strategic Policy Framework* and in 2012 New Brunswick released *A Primary Health Care Framework for New Brunswick*. Alberta uses primary care networks, and Ontario use several models, including family health groups, family health networks, family health organizations, family health teams, and community health centres.

The recent restructuring of the Nova Scotia health-care system presents opportunities for

physicians, working with DNS, to collaborate with the DHW, NSHA and IWK to work together to advance a shared vision for primary care in Nova Scotia.

New models of care and physician payment models will need to be considered if Nova Scotia hopes to establish a primary care system that addresses the principles of primary care outlined above.

After looking at primary health care and collaborative care team structures in other provinces and reviewing feedback from family physicians, DNS makes the following recommendations.

FLEXIBILITY IN THE SYSTEM

We recommend that physicians be given the opportunity to choose what type of practice they want to work in and develop.

It is important to remember that there is not a one-size-fits-all approach to providing primary care. Physicians, patients and communities throughout Nova Scotia require flexibility in how they deliver and receive care. In some cases, a solo family practice as part of a larger network might best meet a community's needs,

while in other areas a collaborative team may best serve a population. In some instances, a patient may only want to receive care from their family physician, while others may prefer accessing the expertise of multiple providers. The health-care system needs to allow for these (and other) variations in practice types.

PATIENT ROSTERING

We recommend that the DHW and NSHA implement patient rostering as part of a new payment model for primary care.

Patient rostering is a commonly used model of organizing patients and providers for collaborative care. The CFPC defines patient rostering in family practice as “a process by which patients register with a family practice, family physician, or team. Patient rostering facilitates accountability by defining the population for which the primary care organization or provider is responsible and facilitates an ongoing relationship between the patient and provider” (CFPC, 2012, p.1).

Many provinces, including British Columbia, Manitoba, Ontario, Quebec, New Brunswick and Prince Edward Island, have implemented some form of patient rostering. Provinces with better developed primary health care have endorsed patient rostering because it can “facilitate the development and strengthening of the continuing relationship between patients and their personal family physician, nurses,

and other team members, which is a critical factor contributing to better health outcomes, particularly for chronic disease management. Patient rostering with a family physician and team also facilitates effective preventive care and supports CQI [continuous quality improvement] activities in the practice” (CFPC, 2012, p.1).

Physicians who work in a patient rostering model are not compensated through an FFS, APP or AFP payment model, but through a model that combines FFS billing and capitation/negation. Additionally, physicians should be provided administrative supports to help establish, maintain and monitor their patient roster. Efforts should be made to ensure physicians are not overburdened with increased administrative or overhead costs or unmanageable amounts of paperwork.

PRIMARY CARE RECOMMENDATIONS

BLENDING PAYMENT MODEL

We recommend that the DHW and NSHA work with DNS to develop a new blended payment model to better support patient care, fair compensation and good stewardship of public funds.

Blended payment models are required to support patient rostering. There are several different models used throughout the country. They usually combine elements of capitation, negation and FFS payment models. Each of these payment mechanisms presents challenges and benefits, but used in combination they provide a comprehensive payment structure that supports better patient care, fair compensation for physicians and good stewardship of public funds.

Capitation

Capitation is a payment structure in which a physician is paid a fixed amount to provide care to a defined group of patients under his or her care. The remuneration unit is the individual patient, not a service or procedure. As some patients require more attention than others, capitation systems usually do not pay the same for every patient but take the patient's health needs into account (University of Ottawa, 2016). Payments for rostering an individual can vary drastically depending on predetermined modifiers such as age and sex.

Negation

It is not possible to have capitation without checks in the system to ensure the stewardship of public funds. This is usually done through a mechanism called negation. Negation is a market-based incentive which avoids over-measurement and over-management of physicians by government, while ensuring government does not pay twice for the same medical service (NBMS, 2016). If a rostered patient receives a capitated service from a primary care physician outside of their usual family practice, the capitated physician who has enrolled the patient could be financially penalized (Sweetman, 2014). For example, if a patient rostered to a certain physician visits a walk-in clinic rather than their family physician for their care, the fee paid to the walk-in clinic is recouped from the family physician's next capitated payment, with a clearly indicated reason (NBMS, 2016). It will be important that capitation is not a disincentive for physicians

to work in a collaborative practice with a blended payment model. Physicians should not be financially penalized for decisions made by patients when the physician is providing appropriate access. Physicians need to be engaged in the development of the negation process to ensure that it fosters appropriate care, does not deter physicians from patient rostering and reflects the realities of family practice.

Nova Scotia will need to develop its own version of capitation that supports communities; however, we will not have to start from scratch. Other provinces have learned lessons that can help Nova Scotia develop an effective blended payment model.

Fee-for-service

Capitation is usually combined with an FFS payment model to encourage productivity and ensure that data is being collected to track the services being provided. Data is an important way to safeguard against inaccurate age and sex modifiers in capitation, and to gain a better understanding of the patient profiles in geographical areas (NBMS, 2016). This can help better develop collaborative care teams to ensure the most appropriate health-care providers are offering the right services for the community they serve.

In a capitation model, doctors do not receive full FFS compensation for the services they bill as FFS because they already receive capitation payments for their enrolled patients. Capitation is considered the base for providing all services. The family physician bills for every patient they see and every service they provide, but the services are paid at a discounted rate (NBMS, 2016).

In a blended payment model, all three components – capitation, negation and FFS – need to work together to encourage productivity, support advanced access and ensure good stewardship of public funds. Other provinces have been able to adopt blended payment models. Nova Scotia has an opportunity to learn from the work that has already been done and develop a solution specific to the province's needs.

PRIMARY CARE RECOMMENDATIONS

NON-FACE-TO-FACE PAYMENT MODELS

We recommend the DHW ensure that compensation is not a disincentive for physicians to provide non-face-to-face services, and that physicians leverage opportunities to provide non-face-to-face services in their practices in order to increase access for their patients.

The most common approach to health care delivery is through face-to-face contact between a health-care provider and a patient. There is, however, an increasing trend toward the provision of health-care in the absence of personal contact, which is known as non-face-to-face care (Stylus Consulting, 2015). Non-face-to-face care refers to linking patients to a health-care team through a videoconferencing platform, or by phone, email or other forms of electronic communication.

In a 2014 Stylus Consulting study of more than 4,200 patient appointments, it was found that e-visits have the potential to fundamentally improve the way doctors provide clinical care. On average, 22 percent of all appointments would have been appropriate (in part or whole) for an e-visit instead. Doctors also reported that providing an e-visit takes them less time than an in-person appointment and that the use of e-visits could open up about two appointment slots each day.

Research indicates that non-face-to-face services can produce cost savings through the provision of better care, which reduces the frequency and/or cost of subsequent health care services. It also provides greater access to quality care, better management of chronic diseases, and a solution to critical physician shortages in both urban and rural areas (Stylus Consulting, 2015).

Helping physicians provide non-face-to-face services is a key component of addressing many of the challenges facing the province's health-care system, such as an aging population, high rates of chronic disease, and recruitment and retention issues. Doctors Nova Scotia recommends that the DHW support adjustments to the Fee Schedule to support any appropriate non-face-to-face interaction between physicians and patients, whether by phone, email, videoconferencing or other forms of electronic communication.

SAME-DAY/ NEXT-DAY ACCESS

We recommend that the DHW and NSHA support family physicians in implementing same-day/next-day access in their practices, and that physicians use this support to improve access for their patients where appropriate.

In high-quality health-care systems, people should be able to see their primary care physicians in a timely manner when they become ill, including on the same day when clinically appropriate (Kiran, 2015). Canada is failing at providing timely access for many patients. According to the Commonwealth Fund (Health Council of Canada, 2014), only 41 percent of Canadians said they could get an appointment on the same or next day when they were sick or needed medical attention. This was the lowest reported percentage among the 11 high-income countries included in the study (Kiran, 2015). As a result, many Canadians access primary health care services in emergency care settings.

Same-day scheduling typically requires that practices “do today’s work today” by offering the majority of patients the opportunity to book their appointments on the day they call, regardless of the reason for the visit (CFPC,

2012). There are different ways for family physicians to implement this model. For example, a practice with an elderly or chronically ill population may need to reserve some appointments for routine care, in addition to accepting patients who call for an appointment that day. There are several practices in Nova Scotia already offering this service to patients. In most cases, family practices offer both same-day and scheduled appointments.

To increase the number of family physicians offering same-day/next-day access, several supports should be implemented, such as increased funding for providing after-hours care, support to address patient backlogs, increased access to collaborative care teams, increased access to PHRs, recruitment of sufficient numbers of physicians to meet community need, and increased access to non-face-to-face services.

PRIMARY CARE RECOMMENDATIONS



**DR. JOHN KEELER
SHELburnE**

Rural family physician Dr. Keeler helps his patients get the treatment they need and gives them the security of having a family doctor in their corner. “When people have a family physician they’re comfortable with, it makes their care a lot simpler,” he says. “It gives them peace of mind.”

RECRUITMENT AND RETENTION

We recommend that the DHW, NSHA, physician recruiters and Dalhousie Medical School work with DNS to develop a recruitment and retention strategy.

In order for Nova Scotia to reform its primary health care system, the province will need to recruit and retain physicians to work in communities throughout the province. The NSHA should work with doctors and other providers to determine what practice structures best support primary care in specific communities. Providing physicians with the flexibility to help design their practices is a critical component in recruiting and retaining doctors in Nova Scotia.

Making the province more inviting to medical students and residents is a critical factor in reaching the province’s recruitment goals. According to the 2012 DNS membership survey, most medical students and residents identified their ideal practice type as a group practice with physicians and other health-care providers. They also indicated they value having a turn-key office with amenities such as EMRs.

Previous iterations of practice environments do not work for the majority of new family physicians entering practice. The province will need to develop creative solutions to ensure that Dalhousie Medical School graduates choose to practise in Nova Scotia.

Nova Scotia is not, for the most part, a net importer of physician talent. In the national marketplace, Nova Scotia is not overly competitive, largely because our physicians are among the lowest paid in Canada. This makes it even more critical that we train and retain young physicians here in Nova Scotia. We encourage the DHW, the NSHA, the IWK, physician recruiters and Dalhousie Medical School to work with DNS to develop a recruitment and retention strategy that meets the needs of Nova Scotians.

PRIMARY CARE RECOMMENDATIONS

FLEXIBILITY IN PRIMARY CARE

We recommend the DHW, NSHA, physicians and other providers develop creative and flexible solutions that produce timely results for patients.

Developing primary care teams will take time. For example, it takes time to implement the infrastructure needed to support large group practices, such as EMRs and office space. It will also take time to find health-care providers who have the interest and training to work in a collaborative primary care setting.

In the interim, there needs to be flexibility in the system to allow for creative solutions to address immediate gaps in services. The provision of primary care cannot slow down to make time for needed changes in the system. It is important that the long-term vision for primary care does not detract from the immediate need for improved access for patients currently without a primary care team and/or family phy-

sician. The DHW, NSHA, physicians and other health-care providers need to develop creative and flexible solutions that produce timely results for patients.

Additionally, health-care providers need to have options to choose from when deciding what type of practice and payment model they would like to work in. Many family physicians will prefer to work in a collaborative care team; however, that may not be the best fit for all providers and communities. Physicians should have flexibility in deciding their practice types, as long as the services they provide align with the needs of the community.

TRANSITIONING SAFELY TO A BETTER PRIMARY HEALTH CARE SYSTEM CURRENT INITIATIVES THAT NEED TO BE CONTINUED

Primary health care access issues, recruitment and retention challenges and increasing health-care budgets demonstrate the need to change how primary health care is delivered in Nova Scotia. However, these changes cannot and should not be made overnight.

Time will be required to develop and evaluate an optimal primary health care system. While moving toward a provincial vision for health care, some of the current systems will need to remain in place to ensure that patient care is not jeopardized.

WALK-IN CLINICS

We recommend that walk-in clinics be maintained during the transition to a better primary health-care system.

Walk-in clinics provide episodic care to patients who do not have a family physician or who are unable to access care from their regular provider in an appropriate time frame. When accessing care through a walk-in clinic, patients rarely see the same provider. This makes it very challenging for patients to receive continuity of care. Patients who do not have continuity of care are more likely to be hospitalized, visit the emergency department and be less satisfied with the health-care system (Van Walraven, 2010). Five of seven studies found increased continuity of care improved patient satisfaction. Walk-in clinics are not the best way for most individuals to access primary care – it might be acceptable for a healthy 20-year-old, but not for an elderly person living with chronic diseases.

Although walk-in clinics do not align with

the pillars of the PMH, they do service a need in communities. Ideally, all Nova Scotians would be able to access care from their own family physician working with other providers; however, we are far from achieving this goal. In the meantime, as we work toward improved access, patients still need care. Walk-in clinics can serve as a transition tool, ensuring patients can access primary care (if not continuity of care) while we work on improving the primary health care system.

While we recognize the shortcoming of walk-in clinics, health-care stakeholders are increasing the level of oversight and working to ensure the clinics deliver the best care possible. For example, the College of Physicians and Surgeons of Nova Scotia has developed the *Professional Standard on the Standard of Care for Walk-in Clinics* (updated 2015).

PRIMARY CARE RECOMMENDATIONS

ALTERNATIVE PAYMENT PLANS

We recommend alternative payment plans (APPs) be maintained during the transition to a new primary health care system, with opportunities to evolve to a blended payment model.

Alternative payment plans (APPs) are individual or group physician funding agreements for the provision of clinical services. Approximately 100 family physicians are funded through this payment model in Nova Scotia. Well-designed APPs support collaborative care because family physicians are not financially penalized for working with other health-care providers. They can remove the competitiveness that is sometimes felt between providers when one is compensated for a service and the other is not. This encourages all members of a team to work to their full scope of practice.

Unfortunately, APPs as currently structured in Nova Scotia present challenges because of their fixed payment structure. Doctors are not incentivized to take on more patients. For example, if family physicians take on more patients, they face an associated increase in costs for supplies, but they are unable to generate more income for their clinic to cover the additional costs. In some cases, this can

create a disincentive to treat more patients.

Additionally, physicians working in an APP structure are constrained to many of the same limitations as FFS physicians through a process called shadow billing. Shadow billing requires physicians working in an APP environment to record the services they provide using the FFS billing structure. APP physicians are required to meet shadow billing thresholds and targets. These targets detract from many of the benefits of the APP structure, such as being able to spend more time with complex patients, and encourage physicians to reach metrics based on volume rather than quality of care.

Ideally, Nova Scotia would implement blended payment models throughout the province to encourage family physicians to collaborate and treat more patients. However, this transition will take time. In the meantime, APPs can provide an interim step toward a blended payment model.

PERSONAL HEALTH RECORD

We recommend the DHW, NSHA and IWK prioritize and invest in the development of a secure electronic health record accessible by all health-care providers.

A personal health record (PHR) contains health data and information; it is shared between a patient and their physician. Using a PHR helps patients take greater control of managing their health, while also providing doctors with important health information about their patients. Personal health records are the first step in enabling physicians and patients to interact using technology. As our e-health system grows, it's important that e-health technologies – such as PHRs, EMRs, the drug information system and the hospital information system – are integrated.

It is also important that physicians are supported in using available technology. This includes removing disincentives that limit physicians' use of e-health technologies. For

example, in some instances physicians lose opportunities to generate income when they use PHRs because they are seeing fewer patients in their office and they are not remunerated for treating patients without a face-to-face visit. Compensation issues must be addressed in order to enable physicians to fully leverage technology in their practices. When compensation issues have been addressed appropriately, the PHR will be an important tool for improving physician access.

In the coming years, Nova Scotia will need to develop an e-health system that connects all providers and health-care institutions; but until then, the PHR called MyHealthNS is an important first step.

PRIMARY CARE RECOMMENDATIONS



DR. CATHY FELDERHOF
PICTOU LANDING

“I want all my patients to feel empowered to play a role in their own health,” says Dr. Felderhof. “By empowering instead of enabling, my patients build on their strengths and can become healthier.”

PHYSICIAN ENGAGEMENT

We recommend that the DHW, NSHA and IWK engage physicians in transforming the primary care system in Nova Scotia.

Physicians are vital members of all health-care teams and have broad training and capabilities. They play a critical role in health-care delivery. They direct, coordinate and deliver patient care, and their perspective reveals the physicians’ experience as well as reflecting the needs of patients.

Physicians have a vested interest in transforming Nova Scotia’s health-care system in order to ensure safe, high-quality health-care services. It has been well established that organizations that effectively engage physicians in health system design, change processes and leadership development opportunities are

most likely to experience improved outcomes (Denis, 2013). Understandably, physicians cannot and do not typically support health care changes or initiatives that they have not been permitted to take part in shaping or that did not consider their perspective. Effective physician engagement is essential to effecting change within any health-care organization and the health system as a whole. As the province moves forward with transitioning primary health care, physicians, through DNS, should be viewed as critical stakeholders by the DHW, the NSHA and the IWK.

CONCLUSION

Physicians have growing concerns about the primary health care system in Nova Scotia. The recommendations outlined in this document are only a portion of the work that will need to happen to shift the current system. Physicians want to work with other health-care providers, patients, the government and the health authorities to fix the primary health care system. Doctors Nova Scotia and the DHW, NSHA and IWK must find innovative and fiscally responsible ways to support physicians, and all health-care providers, in providing primary health care to Nova Scotians. By investing in primary health care teams, adopting new payment models for physicians, improving e-health systems, and recruiting and retaining physicians, Nova Scotia will be able to improve its primary health care system.

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