Overarching Questions

1. **What is the new APP Accountability Framework?**

   The APP Accountability Framework is a method of ensuring transparent, fair and consistent remuneration of physicians via a fixed-rate contractual funding model in exchange for meeting contractual expectations that benefit both Nova Scotians and physicians in the delivery of needed medical services.

2. **Why are we making changes to the current APP Accountability Framework?**

   Both Doctors Nova Scotia (DNS) and the Department of Health and Wellness (DHW) strongly desire to continue APPs as a funding option for both current physicians and potential new recruits. At the same time, there is a need for clear accountability and greater stability within the APP funding model.

   The 2019 Master Agreement included a commitment to develop a new framework for contracting physicians on APPs. Our objective with this new framework is provide contractual clarity on how APPs will support physicians and the needs of Nova Scotians. By developing a more robust model, we can better ensure all stakeholders (physicians, patients, the government and the health authorities) have confidence in the APP model well into the future.

3. **Who is affected by this change?**

   At this stage the new framework is focused on family physicians in solo or collaborative practice. The work on other specialist arrangements, as well as family physicians in Group APPs or other unique practices (such as geriatric/palliative care, rehab, CECs, GP oncology and First Nations work), will immediately follow.

4. **Will the contracts be with DHW and the deliverables be with NSHA? How will these 2 groups work together?**

   The contracts are between DHW, DNS, NSHA and yourself as the provider. As we do now, deliverables are negotiated based on the needs of your community, defined jointly by DHW and NSHA, in collaboration with the physician.

5. **Will our pay reflect our increase in accountability?**

   The APP accountability framework formalizes the expectations that already exist for our APP contracts and are remunerated at the rate negotiated as part of the Master Agreement.

6. **Will there be a way to quantify specific things requested by NSH for leadership or mentoring within a collaborative practice?**

   With the focus of APPs being the provision of clicnical services to Nova Scotians, it is our intent to ensure as much clarity as possible around non-clinical work within deliverables. We also anticpate nuances with respect to collaborative practice. We are currently negotiating contract templates that will inform this conversation. More to follow.

7. **Will these accountability measures begin now (as of April 1, 2022) vs. looking backwards to label people as red, yellow, green. I ask this as a physician who is new to NS in the last two years who moved from a 1.0 FTE to 0.8 FTE in the last year. Previously shadow billing reports have never taken into account these changes or unpaid leave.**

   Accountability measures will not formally come into effect until the new contract starts April 1, 2023. You are being provided with the information now to inform you of your shadowing billing performance against the threshold prior to your new contract offer and to allow you to implement any changes you may wish to make to optimize your success before that contract commences.

8. **Will there still be a requirement to complete the Accountability questionnaire (sent out April of each year) - as some of the things that are asked to be quantified are not realistic. I understand the leave of absence form is needed but the other document does not provide a true representation of what I do.**

   I believe this question refers to the Activity Report and LOA form required under the existing APP arrangements. Though you will be required to notify DHW of absenses and will be given the opportunity to provide feedback at any time, we do not anticipate the requirement for annual activity reports. Our intent is to minimize administrative burden on physicians wherever possible.

9. **So no claw backs until April 2023 onward?**

   You are still required to meet the terms of your existing APP arrangement. There will be no retroactive adjustment to your existing APP arrangement related to not meeting shadow billing or panel size.

10. **How will locums be affected when these changes come into effect? I will be on maternity leave when the new contract/deliverables start with locum coverage, who has already been approved for my existing APP deliverables.**

    Though all providers need to be accountable for the work they do, the APP accountability framework under Wave 1 will not consider services provided by locum providers at this time. Work done by a locum physician will not impact your accountability metrics.

11. **Is this a mechanism to have APP physicians convert to blended capitation? Is DHW wanting to have fewer APP physicians?**

    DHW's intent is to ensure that APP remains a solid, stable and valuable funding model moving forward. As Blended Capitation is only in the pilot stage, we can't speculate on how that funding model will progress at this point, but it is likely that even if such a model were to be implemented in Nova Scotia, an APP model might still be valuable in certain cases. We do not anticipate an end to APP as a funding vehicle.

12. **Is it safe to say that with all of the new work going into APPs, we are certain they will be continued beyond the March 31 2023 expiration date?**

    Yes, the intent is that APP will continue beyond March 31, 2023.

13. **How are you measuring capacity? Panel size only? Next available appointment? Patients' use of Emergency or walkin clinics?**

    At this initial phase of the APP accountability framework, shadow billing and panel size are the available metrics. We want to grow beyond the limitations of these metrics to further refine our understanding of capacity to inform support requirements, resources and access to care. So, for now, yes. But not for always. Make sure you engage us in data-supported conversation during baselining so that we can understand your ideas and how they might inform future measurements.

14. **What about new physicians? It takes time to onboard and billings won't be high enough at first. Will I still get the reports? How will it be handled?**

    New physicians will still get reports and will still be measured as we see that as an important part of consistency and transparency, but we know that there are unique considerations for new providers. We value the learning curve so we are working to determine how contracts and/or expectations for these providers might be different and how they might evolve. More to follow.

15. **Will the panel size metric affect the evaluation of green or yellow? What is the conversation if a physician doesn't hit their target panel size?**

    Though it is our intent to move toward accountability targets related to panel size, we need to understand this indicator better before confirming how it will be incorporated into the metric.

16. **Can you please expand on voluntary FTE reductions based on performance?**

    This question seems to be a mix of two different points in the process. Prior to the signing/start of APP accountability contracts on April 1, 2023, any adjustment to FTE will be purely voluntary based on how you see your performance. That is why we are providing your practice profiles now – to inform your contract and decisions. Once the accountability contracts take effect on

April 1, 2023, three "red" reports in a rolling 12-month period will result in non-voluntary FTE reduction to match your performance. [Note that if a physician would prefer a retroactive adjustment of funds paid instead of an FTE reduction, this is something that can be discussed with DHW at the time.] Of course, at any time, if you feel you wish to voluntarily adjust your FTE for your own reasons, you should contact DHW to discuss.

17. **Will I be issued a new APP contract? If so, when?**

    Yes, you will be offered a new individualized APP contract toward the end of 2022/early 2023. This contract will include your assigned thresholds, be informed by our conversations with you and will also include your negotiated deliverables (more on this in fall 2022). Though we do not expect significant deliverable changes from your existing contract, the new contract does provide an opportunity to refine deliverables if you or NSHA/DHW desire. The contract start date will be April 1, 2023, for all contracts.

18. **What happens if I don't agree to sign my new APP contract?**

    If you don't agree to sign your new APP contract, other funding models such as fee-for-service (FFS) remain available to you. We value the work you do and want your funding model to reflect how you choose to meet the health care needs of Nova Scotians.

19. **How do these changes encourage new physicians to join community-based family practice or encourage retention?**

    Feedback indicates that some physicians feel APP is less transactional and supports a more holistic form of practice. Others just prefer the stability of a fixed income in exchange for meeting clear expectations. Being clear on the funding models available and the expectations support retention of physicians.

Shadow billing

1. **Shadow billings alone are not a great reflection of my actual practice. Why are we using this as a measure?**

   Stakeholders agree that shadow billings alone are not fully indicative of total productivity and capacity. Shadow billing provides valuable information relating to what services Nova Scotians are accessing in a way that is standardized across funding streams, is fundamental to reciprocal billing for patients from other jurisdictions and informs provincial comparisons. It is the intent of the APP framework to evolve performance metrics to further contextualize shadow billing, considering aspects such as quality of care and access. Shadow billing and further metric refinements will provide valuable information to decision makers about physician resource planning, obstacles to primary care delivery, recruitment needs and physician burden.

2. **What is included in my shadow billing percentage?**

   Your APP shadow billing percentage = (Total Shadow Billings / Total contract earnings) x 100. Chronic Disease Management (CDM) and Clinical Geriatric Assessment (CGA) codes are included in your shadow billings. It does not include fee-for-service/sessional/stipend earnings gained outside of your APP deliverables, nor any bonus received.

3. **Can you somehow monitor EMR time as an indicator of work being done and time spent on patient care and activities? As you know shadow billing is not really an accurate measure of work being done.**

   The province does not currently have access to EMR time for all physicians so this can't be applied as a refinement unilaterally, but it would absolutely be the type of data-driven information that would help inform conversation on unique practices. It is also the type of information we will consider in refining metrics as APP accountability evolves.

4. **In a previous slide, it is mentioned that shadow billing is linked to office-based visits only? If an APP includes walk-in clinics/after hours clinic care, does shadow billing include patients seen in those clinics?**

   If the deliverables in your contract include after hours care/walk in clinic then this should be included in your shadow billing total. If there are any questions, please reach out to DHW to confirm.

5. **How will the non-billable services we perform be accounted for in this (e.g., asynchronous care)?**

   Unlike fee-for-service, the APP model does not require 100% billing. In this way, the APP model already recognizes that some of the work done by physicians is not billable.

6. **Why is the shadow billing requirement different in Central Zone? How was it decided upon the 70% Central Zone office-based vs 60% for rural office-base only? I understand the difference if there is work outside of the office, but for purely office-based services what was the rationale for the difference?**

   Shadow billing targets were developed considering a variety of factors:
   - the type of Family Physician APP you have (rural, urban, comprehensive)
   - availability of additional supporting health services; and
   - demographics and socio-economic status (SES) as indicators for health care need by community cluster.

   Shadow billing thresholds have initially been set based on three categories: Central zone, Rural (including Central Zone rural such as Musquodoboit Network and Hants corridor) and Rural Comprehensive. It is fully recognized that may not represent all providers in a given catchment.

Physician feedback to understand practice variations will allow adjustments to shadow billing thresholds for groups of like providers (to ensure consistency and fairness) when supported by additional data and context.

In reviewing Central Zone shadow billing overall, it was recognized that the majority of providers in Central Zone are already able to meet higher levels of shadow billing than the majority of rural providers due to the factors noted above and consistent volume.

It is also important to remember the origins of APPs and the kind of practice they were originally designed to support. APPs were originally designed to support family medicine in small, rural communities where the population size itself would be insufficient to support a fee-for-service practice, or where the number of family physicians needed to keep the local ED open was higher than the population alone would necessitate, which again creates a situation where a fee-for-service practice is not sustainable. Those communities are still supported with APPs today. The environment in Central zone is generally different. Not only is the base population more sizeable, but the data also suggests that patients in Central Zone generally tend to be younger and from a higher socio-economic population, whereas patients in rural areas tend to be more elderly and chronically ill, which means longer patient visits. This is not uniformly true, of course, which is why we are prepared to consider data-driven exceptions for practices in Central Zone that have a unique patient population (such as higher newcomer patients, as one example).

Panel size

1. **I would just like to point out that in a collaborative practice that provides cross coverage for same day access, I would bill ME=CARE codes for patients that are not attached to me but someone else in the practice, including the roster of the NPs. How will this be handled?**

   We aren't sure yet. There is still a lot of work to do to understanding panels and this is one very important aspect. More to follow.

2. **Is the socio-economic status (SES) lens based on the community where the provider is located, or the community where the patient lives? (Accounting for rural providers who have patients who may live 150km span or more apart)**

   We had to start somewhere. Identifying providers by community cluster is likely to work for the majority of providers but we know there are important exceptions which is the reason that we want to understand some of the unique considerations of our providers. Please engage with us directly during the baselining phase to ensure we understand your practice context.

3. **Does SES (socio-economic status) take into account the number of years patients have been on the 811 list? Taking someone off the 811 list after they have been on it for five years or more makes them way more complex, especially in the first year.**

   SES is based on census data and does not look at the Need a Family Practice Register (NFPR)/811 list. However, we know that when we are discussing additional patient attachment from the NFPR there are complexities, which is why the conversation can't be just about numbers. More to follow as we learn more about panel size and attachment possibilities.

4. **I am currently paid based on the 1350 patient number. If my new target in Bedford is, say, 1600 then my pay will go down as I am unable to take new patients. When will this happen?**

   1350 is a global target that has been used as a general metric for yearsand doesn't reflect things like SES. We are still learning about panel size, so we look forward to further conversation with our providers. New panel size targets will not be finalized and enforced in this first phase of the APP accountability work. We will keep you apprised of timing on that and will provide ample notice before the new targets are introduced.

5. **Will individual practice demographics be taken into consideration when determining target size (such as age and number of complex care visits or CDM billings)?**

   Individual practice demographics will absolutely inform conversations on appropriate metrics for your practice. However, it is highly likely that there are similar practices within the province. When making threshold adjustments, we will be focused on fairness and transparency and will ensure adjustments are in line with like providers. Your practice profile will help determine those similarities.

6. **Is there some data showing what percentage of practices are currently meeting their target panel?**

   We know that our understanding of physicians' current panel size is incomplete, so we aren't able to say at this point, but hope to be able to soon. When we do, we can share that provincial overview similarly to how we showed the distribution for shadow billing in the webinar presentation.

7. **I don't quite understand. To be clear, are you trying to increase our panel size?**

   We won't know until we understand your current panel, because we know there are gaps in our understanding of who is currently attached to a given provider. We do expect that there will be some physicians with capacity to attach additional patients, but we absolutely know that that is not true for all providers.

8. **Does the panel size that you are calculating take into account the thought from NSH that having an NSHA-allied health member (like an FPN) should increase the group's capacity by a certain amount?**

   We are looking at how collaborative practice affects panel size, so more to follow when we know more. It is also NSHA's intent to mirror our community cluster panel size calculation for allied health professionals informed by this work. Still lots of work to do before we get there though.

9. **Where is the SES (socio-economic status) data coming from?**

   It is the most recent census data available from Statistics Canada.

10. **I am moving my practice from one area to another, but my patients will follow me. How will my panel size differ given that I still have the same amount of deprived patients, but I work in a more affluent area due to an office move?**

    This will be a unique practice consideration that can be addressed through baselining conversations.