Doctors Nova Scotia's Community Listening Tour

Physicians in Nova Scotia are under pressure. Faced with large patient rosters and limited resources, they are worried about their patients, their practices and their personal lives. That's why this spring, members of Doctors Nova Scotia's (DNS) senior leadership team embarked on a province-wide listening tour. They attended 29 meetings with a total of 235 physicians in 24 communities – learning about the challenges of practising medicine in Nova Scotia from people who are experiencing them first-hand.

Doctors Nova Scotia held 11 meetings in your zone. This report summarizes the discussion DNS staff members had with physicians in Halifax, highlights key themes in your area and across the province, and outlines what DNS is doing to help.

Community Report: Halifax

Meetings in Zone 4 – Central

Location	Date	# of physicians
Cobequid Community Health Centre	May 18	16
Twin Oaks Memorial Hospital	June 7	3
Musquodoboit Valley Memorial Hospital	June 7	2
Eastern Shore Memorial Hospital	June 7	3
QEII – Veteran's Memorial Building	June 13	4
Dartmouth – NSCC Waterfront Campus Dartmouth	June 14	8
Spryfield Medical Centre	June 14	7
St. Margaret's Community Centre	June 21	13
Dalhousie – Collaborative Health Education Building	June 21	4
IWK	June 22	2
Gladstone Family Practice Associates	Sept 10	15
E-mail correspondence	Aug-Sept	5
TOTALS	**11 meetings**	**82 physicians**

Issues in Halifax

The association held three sessions in downtown Halifax (at the IWK, the Veteran's Memorial Building and Dalhousie's Collaborative Health Education Building), but attendance was very low. This is in part attributable to physicians leading very busy lives, but it may also be a reflection of the lack of connection and community among physicians in Halifax or a lack of confidence in DNS's ability to influence change. The association reached out to physicians at some of the larger clinics in Halifax (such as Duffus Health Centre, the North End Health Clinic and Gladstone) to ensure they were given the opportunity to incorporate the key issues and challenges they are dealing with into this report and to ensure those issues are represented by DNS's advocacy efforts. As a result of this secondary outreach, DNS staff members were able to meet with the Gladstone Family Practice Associates and received feedback from others via

email. Doctors Nova Scotia staff will also be meeting separately with physicians in Clinical/Academic Funding Plans at their departmental meetings this fall.

These Halifax-based physicians expressed concerns about the following issues:

Absence of relevant data for physicians

- Physicians raised concerns about an inability to access relevant data that would help them be more effective in their practices. For example, they have no idea what their own wait times are because the data is not available to them.
- Quality improvement research supports the notion that metrics physicians can measure themselves against are the most motivating and transformational. Once that information is made available, DNS could facilitate information exchange to help physicians better understand how to make changes for improvement.

Billing system

- Physicians feel that the current billing rules are designed for the one percent of physicians who might try to abuse the system, at the expense of the 99 percent who would not. The new non-face-to-face fee codes are just one example of this.

Contracts

- Family physicians want to serve their patients well, but their contracts are not helping to facilitate that. New physicians coming through the system will not accept the terms of the current contracts.

Compensation/fees

- In general, there is a sense that Nova Scotia typically falls in the bottom three provinces for compensation/fees. Family physicians in the province feel they are paid neither equitably nor competitively. The office rate has gone up, but patient expectations for face-time with physicians has increased, as has the complexity of patients, so the potential for revenue has actually gone down.
- Government has expanded the scope of other health-care professionals to deliver some care traditionally delivered by physicians (for example, immunizations); one of the benefits of this approach was cited as giving family physicians more time to focus on the most complex cases not seen by others. However, the fee-for-service payment model does not support this approach. Because it takes more time to care for those more complex cases, family physicians now need to work longer and longer hours to see the same number of patients and earn the same income. The infrastructure to support the delivery of primary care is largely paid for by physicians. The government's lack of engagement of the physician community in making these changes is analogous to telling Eastlink that the government will be taking away their ability to make income through data charges, and instead giving that income to Bell, while Eastlink keeps local calling

and long-distance services instead. The way these changes were made without engagement feels disrespectful to physicians.

- Within the fee-for-service model, there are a number of problems:
  - Poor payment for complex referrals.
  - Non-face-to-face billing criteria are too cumbersome for the money earned.
  - In order for a specialist to call a patient, the doctor has to send a note to the referring physician, which costs more than the fee associated with calling the patient.
  - A lack of effort to address the inequity between the value of services provided by family medicine specialists and surgical specialists. The inequity continues to grow, to the disadvantage of family practice physicians.
- There needs to be an appropriate payment model that supports the incoming generation of family physicians, as they will not tolerate the current situation. A blended payment model is likely best; it would allow physicians to take care of their patients properly.
- Physicians wondered if there is perhaps an opportunity to pilot and evaluate a few blended payment models in Nova Scotia now, before the next round of negotiations (the current Master Agreement expires in March 2019).
- Provincially speaking, the cohort of physicians is a large employer. Government pays physicians to deliver care; physicians pay others, such as nurses, nurse practitioners, other allied health professionals, administrative assistants, bookkeepers and so on.
- Physicians need fairness across the province – for example, now there are APP physicians who don't have to pay for overhead costs, while some fee-for-service physicians pay upwards of 40 percent overhead. Physicians should receive the same payment for the same work, and more payment for more work. Equity across payment models is important.
- The health-care system should support family physicians by paying for other caregivers in the team (such as mental health professionals, nurse practitioners, dieticians, social workers and so on). Fee-for-service physicians still get paid $32 for an office visit, despite having more and more demands placed on their time, but upwards of one-third of that payment goes to pay for other allied health professionals.
- Electronic communication with patients should be compensated. Physicians can and should be leveraging technology for greater efficiency, greater access and greater patient satisfaction. The only thing in the way is Nova Scotia's antiquated fee structure. MyHealthNS is one example – physicians have the technology and the opportunity to engage patients with modern technology, but there is no compensation structure in place.

<u>Connection with colleagues</u>

- It is difficult for physicians in the Halifax, Dartmouth and surrounding areas to reach and connect with other local physicians, leading to a sense of disconnection. Part of the

problem is that family physicians have largely stopped doing in-patient care, so they are not in the hospitals where they used to connect with colleagues on a regular basis. This issue impacts a small geographical area, but a large number of practices and individual physicians, resulting in a lack of connection and community.

Doctors Nova Scotia

- Doctors Nova Scotia can support innovative practices such as having general internists going to family practices and running clinics (the sub-specialist is incentivized to go to family practices instead of bringing the patients into the hospital to see the specialists). This would be a great system to help build capacity and experience shared learning and shared responsibility.
- Physicians would benefit from more business of medicine supports in the area of managing their practices. It is sometimes more cost-effective to hire someone to manage aspects of a practice to free up the physician to deliver care. Small practices outside of a collaborative care model can also share in the payment of allied health professionals. Education in this area would be helpful.
- Doctors Nova Scotia needs to connect with its members more often and in a more meaningful way. Many physicians feel like the association does not necessarily represent their needs and often feel the realities of their professional lives are not appropriately reflected in some of the association's communications to the public.

Primary care

- Family physicians feel that they are not valued by the government, the Nova Scotia Health Authority (NSHA) and DNS.
- There has been a slow, steady erosion of the value of family physicians. Things like increases in emergency physician and hospitalist rates, the transition of the Comprehensive Care Incentive Program (CCIP) to fees, pay relativity, loss of autonomy, and lack of input to system and primary care planning have all contributed to family physicians feeling undervalued by the system. The cumulative effect is that family practitioners, especially comprehensive, full-scope practitioners, feel like the system has been telling them consistently that their style of medicine is not valued.
- Fewer family physicians are providing inpatient care to their patients, which interrupts the continuity of care they used to be able to provide. This is partly due to poor compensation for these services compared to seeing patients in the office setting.
- The use of nurse practitioners to provide family medicine is not appropriate and likely not cost efficient. Nurse practitioners do not have the same level of training or education as a family physician. Nurse practitioners who see one to two patients per hour, do not pay overhead and receive a generous salary are likely costing the health system more money. It would likely be more cost effective to improve how family

physicians are treated and valued in N.S., because it would lead to an increase in recruitment and retention of family physicians.

- Some physicians are concerned that the government's vision of collaborative care may be *less* cost-effective and provide *less* access to care for Nova Scotian patients in the long term.
- There is a steadily increasing number of additional expectations placed on primary care physicians who do not have the time and are not trained or compensated to do these things effectively (for example geriatric care, palliative care, mental health care, cancer care with no training and post-operative follow-ups).
- Physicians at the IWK are seeing high numbers of patients in emergency who could be treated elsewhere. One of the emergency medicine pediatricians had an idea to bring these numbers down. It was suggested that an urgent care clinic be set up off-site from the IWK to handle less urgent complaints (such as bumps, gastritis, bronchitis). This clinic would be staffed by an emergency medicine pediatrician and a nurse, and would ensure appropriate immediate care while lessening the volume and congestion at the IWK.
- Another suggestion to practice more effective primary care would be to have sub-specialists hold booked days in family practice offices. This idea came from a site where a psychiatrist would visit a rural primary care office one day a month. This saved the patients from having to travel to the psychiatrist's office, and the family practice physicians got the benefit of discussing cases with the specialist.
- Retired physicians suggested there is no alignment between what patients need and what medical school educators want to teach.

<u>Recruitment/retention</u>

- There appears to be no support for generalist medicine. Physicians feel like there is still a culture that favours sub-specialization and they believe that this culture definitely exists among NSHA recruiters. Medical schools understand this challenge, but the culture of sub-specialization continues to be promoted.
- Nova Scotia Health Authority recruiters are not promoting generalists in their recruitment discussions.
- New family medicine graduates are not staying in Nova Scotia, and they are certainly not doing full-scope, community-based, comprehensive care. If comprehensive family medicine is not a realistic expectation, perhaps it's time to stop recruiting to those vacancies and come up with a different model.
- Why aren't new graduates prepared to go into full-scope family medicine? Because the system does not value that level of care. If compensation is a driver, sub-specialization within a family practice can get you close to specialty-level payment. This emphasizes the need to pay comprehensive practitioners more competitively.

- There should be more effort made by Dalhousie Medical School and the NSHA to connect graduating residents with family practice clinics that are seeking new physicians. There also needs to be assistance with resources to allow family practice physicians to take on medical students and residents in their clinics.
- For many physicians, feeling valued is about more than just compensation. Lifestyle is important, and the reality is that subspecialised medicine (locums, clinics) often offer more contained hours.

Succession planning

- Physicians would like to see better succession planning (for example, the ability to phase out of their practice as new physicians are phasing in).

Addressing the issues in your community

Doctors Nova Scotia staff members tracked the issues and action items that arose from each community meeting and have assigned staff members to certain action items. The action that arose from your community meetings is:

- Doctors Nova Scotia will explore opportunities for physicians in the central zone to connect with one another in innovative ways. This is a longer-term issue that will require engaging physicians to get a better sense of what kinds of connections would be meaningful to them and realistic to plan.

Issue themes across the province

Many of the issues discussed in your community reflect concerns DNS has heard from physicians across the province. These concerns can be grouped into five themes:

Fragility of the physician workforce

- Including the shortage of physicians in Nova Scotia, persistent recruitment and retention concerns, lack of succession planning, lack of support for new physicians, and physician stress and burnout

Loss of professional autonomy and satisfaction

- Stemming from a loss of local authority and decision-making at the Nova Scotia Health Authority (NSHA), a lack of clarity about how, why and by whom decisions are made, a feeling of disconnection from the NSHA, and a loss of connection within the physician community itself

Demise of comprehensive family medicine

- Including excessive workloads, the fact that comprehensive family practice is increasingly an unsustainable business model, unintended incentives away from comprehensive family practice, and the absence of viable alternatives to the fee-for-service payment model

Unsustainability of rural specialty services

- Including unsustainable call schedules, recruitment and retention challenges, lack of succession planning and loss of local authority and decision-making

Lost opportunities to leverage technology

- Including the new non-face-to-face fee codes, which many physicians feel are cumbersome, and lack of compensation for physicians using MyHealthNS

Most of these themes reflect broad, systemic issues that are beyond the association's ability to resolve independently. However, even if DNS can't resolve the issue directly, the association can help members by ensuring that key health-system leaders understand the importance of resolving these issues in a timely manner.

Provincial next steps

- ***Provincial report and recommendations*** – Doctors Nova Scotia staff members are preparing recommendations on how best to address each of the themes identified above. In many cases, these recommendations will be based on solutions suggested by physicians. These recommendations will be outlined in more detail in the in-depth provincial community meeting report, which will be shared with physicians and key health-system leaders in September.
- ***Advocacy*** – Doctors Nova Scotia will continue its advocacy efforts on these priority issues that require collaboration with and leadership from other stakeholders, including the NSHA, the IWK, Dalhousie Medical School and the provincial government.
- ***Community-specific issues*** – Doctors Nova Scotia staff will continue to carry out any action items that are within the association's scope of work, and to advocate for resolutions to issues that are specific to individual communities.

Community support

These community meetings were a first step in the association's work to improve communication and connection with its members. Starting in September, each zone will have a dedicated DNS staff member. Their job will be to help DNS better understand your practice and community needs, and to help you solve problems and better navigate the system. This

dedicated staff person will be your connection to DNS. If your concerns aren't reflected in this report, your dedicated DNS staff member will be available to listen, advise and help you resolve the issue.

Your dedicated staff member is:

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Follow up

If you have any questions or comments on anything included in this report, please email community.outreach@doctorsns.com.