NEWFOUNDLAND AND LABRADOR
MEDICAL ASSOCIATION

March 21, 2016

Honourable John Haggie
Minister
Department of Health & Community Services
West Block, 1st Floor, Confederation Building
St. John's, NL A1B 4J6

Honourable Cathy Bennett
Minister
Department of Finance
Main Floor, East Block, Confederation Building
St. John's, NL A1B 4J6

Dear Ministers:

Subject: Recommendations related to Health System Budget

The Newfoundland and Labrador Medical Association (NLMA) is pleased to present to the provincial government its recommendations related to the province's serious fiscal situation.

The NLMA represents approximately 1,250 practising physicians, as well as medical students, residents and retired physicians. Our members have a deep and abiding pride in the accomplishments of the health system. They want to preserve the quality of health care services and, at the same time, assist Government in reaching its fiscal goals.

To develop our advice, we launched an extensive consultation process with our members and their patients. We conducted four regional physician town halls, an online physician survey, three patient focus groups, a patient survey with 800 respondents, and a provincial conference of physicians.

Our advice is categorized into the following themes: utilization management; role delineation of health care facilities; use of technology; end of life care; system coordination; and, accountability.

Patient Survey Results

Before addressing each topic, we would like to highlight several of the findings in the survey of patients, and reinforce several of the sustainability initiatives on which Government and the

NLMA have already embarked.

- Patients in the province have mixed feelings about the quality of health care in the province; 52% rate the overall quality as excellent or good, while 47% rate it fair or poor.
- Most patients ¬– 91% – have a family doctor, although a third of that group find it difficult to get an appointment when they need one.
- One of the problems for people with their family doctors is the high rate of physician turnover, especially in rural areas.

- Over 40% of patients have been with their family doctor for less than five years and, among this group, the average duration is two years. The main reason for high turnover is that their doctor moved out of their area. For people who do not have a family doctor, 62% use emergency departments to receive their primary care.
- To help alleviate the issue of access to family doctors, many patients – 91% – are comfortable with receiving some types of health care from other health care providers (e.g., nurses, nurse practitioners, pharmacists) who work on the same team as their family doctor. They are also generally comfortable – 71% – using telehealth as a way to have access to their doctors for some types of appointments. The two most preferred technologies are telephone and video-conferencing.
- Many patients also realize that travel within the province is an essential part of accessing health care. The average amount of time patients currently travel, one way, to see their family doctor is 25 minutes, and on average they would be prepared to travel 39 minutes. To have a surgery or another hospital procedure, the current average travel time is 48 minutes and patients would be prepared to travel an average of 101 minutes.
- Patients also recognize that, for certain reasons, a merger or centralization of health care services is supportable. While 41% of all patients support merging or centralizing as a general concept, this support grows to 71% if it is necessary to recruit and retain doctors and other health care providers, and 74% if it is needed for safer and higher quality care.
- These survey results show that patients are open to change in the way that health care is delivered or located, but they want to be sure that health system improvements are the reasons for change and not just for cost-reduction purposes.

Current Joint Sustainability Initiatives
In recent months the provincial government and the NLMA have embarked on two initiatives that are building blocks for the sustainability of our health system: primary health care renewal and electronic medical records (EMR). Each of these initiatives are equally as important in controlling cost growth in the health care system as any of the recommendations below.

- Primary health care renewal will promote physicians offering comprehensive and continuous care to their patients, which will keep patients in their homes and avoid expensive hospital admissions or emergency department care. We look forward to rigorously measuring the impact of the renewal program to ensure we are achieving these kinds of results.
- Similarly, the EMR initiative gives doctors the fundamental tool to manage higher quality, coordinated care for their patients. Cost savings and avoidance can occur through reduction of duplicate tests, point of care access to clinical guidelines, greater patient safety, and better referrals and consultations with specialists. It is essential that the provincial government remain committed to these initiatives as part of the transformation to a more efficient health care system.

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The recent Memorandum of Agreement (MOA) between government and the NLMA also included two features that focus on sustainability. The first is a fee code review mechanism to ensure that the MCP billing system is fair and equitable. The second is a mechanism to review opportunities for offering services in physician offices that are currently restricted to hospital facilities. The expensive physical space and support costs of offering certain services in hospitals could be reduced if we focus effort on identifying opportunities in this area.

We are very pleased with the partnership approach of the provincial government. The MOA is a mechanism to help facilitate change and forward movement, and can be used to accomplish additional joint initiatives in the future. The MOA is the essential ingredient that keeps the goals of physicians and government aligned in support of shared health care goals.

Recommendations from our consultations

The following recommendations are based on the consultations with physicians across the province. They include both short, medium and long-term actions that help to improve quality while reducing costs. We realize that the provincial government seeks immediate and significant cost reductions. We believe that any reductions must occur within a framework that also seeks to positively transform the health system. It would be wrong to reduce costs without curing some of the fundamental problems of the health system that have persisted for many years. Our recommendations attempt to marry both imperatives.

1. Utilization Management

While positive steps have been take in recent years to reduce the volume of inappropriate or unnecessary tests, investigations, procedures and treatments, more can be accomplished. Our recommendation is to create a provincial utilization management program with compulsory participation to reduce over-utilization of diagnostic investigations, clinical treatments and prescriptions. While doctors regard independent clinical judgement as the hallmark of the medical profession, they also understand the benefits of utilization management in the stewardship of scarce health care resources.

Our members identified many promising directions: the use of peer data on utilization so that doctors can self-correct their utilization to peer norms; the use of clinical practice guidelines and the guidance provided within Choosing Wisely Canada; the need for publicly available cost data on tests, treatments and prescriptions so that patients and providers can be aware of the enormous expense of inappropriate utilization; the lack of consistency of utilization rules across RHAs; the need to build utilization guidance and prompts into electronic point-of-care tools (e.g., to inform the provider if similar tests were recently performed, to provide clinical guidelines, or to advise of a less expensive or more appropriate test); and, the need to revise certain protocols in hospitals that result in duplicate or unnecessary testing.

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In the short term, we recommend: 1. Formally adopt a NL version of the Choosing Wisely Program; 2. Establish a Provincial Utilization Management Committee, including NLMA; 3. Identify tests, procedures and treatments that can be reduced or eliminated; 4. Develop peer utilization data reports; and, 5. Engage the NL Centre for Health Information and the resources of the Translational Personalized Medicine Initiative (TPMI) to conduct the data analysis on which to base further programming and interventions.

In the medium term, we recommend: 1. Establishing a Provider Education Program and a Patient Education Program; 2. Online access for all physicians (through EMR and Meditech) for test results, guidelines and prompts; 3. Revising sub-optimal protocols in hospitals; and, 4. Publish the cost of various tests, treatments and procedures.

In the long term, we recommend ongoing evaluation of results, setting new targets, and continued identification of opportunities.

2. Role Delineation of Facilities

Long-term sustainability of health services must be based on a structure and distribution of health facilities and services that is appropriate for the population being served. Therefore, our recommendation is to establish a working group of independent experts to recommend the role and service offerings for each public clinic, health centre and hospital in the province, and report to Government by December 31, 2016. In conducting their review, the expert group will develop and apply a role delineation framework.

Our members recognize that the basic facility/service profile has been unchanged in 30 years or more, yet the population of the province has shifted geographically and demographically. It will also continue to change in the future in a reasonably predictable way. New health-related technologies have transformed the care environment and the means to access health care providers, yet only modest steps have been taken in NL to seize full advantage of these advances. NL's hospital costs are the most significant outlier of all the components of health care spending compared to the national average. There is no consistent methodology for role delineation of facilities and services in NL, yet such methodologies are available elsewhere. The NLMA has reviewed the methodology used in several Australian states, known as "role delineation", and we believe it offers a sound and sensible approach for application and customization to NL circumstances. The regional planning capacity of the Departments of Health and Community Services, Finance (as exemplified in the Community Accounts), and the RHAs, can be deployed in support of an independent group to develop a role delineation framework in the current calendar year so that it can inform budget decisions in future years.

In the short term, we recommend: 1. Government create an independent expert group and establish terms of reference in conjunction with NLMA and others to develop a NL role delineation framework; 2. Complete work by December 31, 2016; and, 3. Incorporate results into budget framework.

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In the medium term, we recommend: 1. Implementation and change management; 2. Address supportive changes in the areas of medical transportation, telehealth and other appropriate areas; and, 3. Develop physician and other health human resource plans consistent with the role delineation framework.

In the long term, we recommend that the framework be evaluated and adjusted at regular intervals (e.g., every 5 years) to account for new population, technology and health needs.

3. Expand Use of Technology

To complement the new role delineation framework, a transformed health system must make maximum use of new technologies that reduce costs, improve access, and raise the quality of care. Therefore, our recommendation is to accelerate the broader use of telemedicine, eConsult, EMR and other information and communications technologies (ICT) in the delivery of health services.

Recognizing that there have been wise investments made in such areas as PACS, the electronic health record, early stage EMR, and somewhat broadened use of telehealth, there remain significant unrealized opportunities. A concerted strategy is needed to put technology to work in support of patients and efficient care. For example, a large volume of specialist referrals can be avoided by implementing an e-Consult platform that will allow specialists to determine whether a family physician referral is needed. The reduced referrals will mean reduced travel costs in the medical transportation program, avoidance of unnecessary tests, and shorter wait times for patients who need access to specialists. Integration of clinical practice guidelines and Choosing Wisely guidance with point-of-care ICT tools will reduce the number of unnecessary tests and treatments. Broadened use of EMR and improved appointment scheduling tools in hospitals will allow appointment reminders for patients to avoid the huge burden of missed appointments. Changing the rules that require physicians to use facility-based telemedicine sites as a condition of billing for services will unleash new capacity in the telemedicine stream, further reducing patient travel costs, improving access, and making better use of physician time. The problems associated with multiple Meditech systems are well known – and the efforts to make the regions compatible through the EHR and EMR will open opportunities for reducing the still-enormous volume of paper used in conveying test results and the related postage budget. The MCP information system, which is the backbone of the entire fee-for-service billing system, is widely understood to be inefficient and outdated. The Department of Health and Community Services cannot obtain the kinds of reports they need on a timely and flexible basis to better manage the physician services program, and doctors still need to acquire ancient modems to file their bi-weekly billings.

In the short term, we recommend: 1. Identification of ICT initiatives (e.g. e-Consult, appointment management solutions to mitigate no-shows); 2. Development of a health ICT implementation plan; and 3. Expanded access to telemedicine beyond “approved” sites through the use of an online portal that meets criteria for confidentiality and record-keeping.

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In the medium term, we recommend: 1.Implementation of new ICT initiatives; 2. Implementation of one provincial medical information system across all RHAs; and, 3. Replacement or upgrading of the MCP information system.

In the long term, we recommend ongoing evaluation of results for impact on patient care, access and cost savings.

4. End of Life Care

NLMA members believe there is an urgent need to adapt our health system to the needs of the frail elderly and people in their end-of-life stage. This level of care is not without cost, but it is less costly than our current model of care. Our recommendation is the adoption of an appropriate strategy for improved palliative care and care of the frail elderly that avoids expensive hospital costs and unnecessary treatments. Also, we recommend the adoption of a provincial strategy for greater use of advanced health care directives.

Our members see a lost opportunity in the lack of access to palliative care and related community support services. There is also a lack of community support services for frail elderly to keep them out of acute care settings. These gaps often result in inappropriate treatment of the frail elderly and patients at end of life, including more admissions for acute care treatment, more testing than may be appropriate, and too many hospital beds filled with patients that require an alternative level of care. Physician expertise also needs to catch up with the growing demand for services to the frail elderly and at the end-of-life stage. There are too few physicians practicing in palliative care and geriatrics. Advanced health care directives can play a positive role in adherence to a patient's wishes at the end of life, and should be in place among a broader proportion of the population. Provider and public education may also be required regarding the sometimes inappropriate or futile treatments that are used at the end-of-life that may actually reduce the quality of a person's life.

In the short term, we recommend: 1. Establishment of a provincial palliative care team to provide advice and support to family physicians and others delivering the service across the province; 2. Establishment of provincial palliative care protocols; and, 3. Promotion of advanced health care directives across all points of entry in the health care system.

In the medium term, we recommend the adoption and implementation of a comprehensive strategy for care of frail elderly using the Primary Care Renewal Program as the starting place for improving physician capacity in this strategy, and reallocating resources from the acute care system into home care and related supports to manage patients at home. A similar approach is recommended for expansion of the palliative care program across the province.

In the long term, we recommend evaluation of results for impact on patient care, quality of life and net cost savings.

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5. Coordination of Services

The doctors of the province see improvements that can be made with better coordinated pathways of care between RHAs. Therefore, our recommendation is that a comprehensive list be developed of clinical services that can be managed provincially along with the appropriate clinical management supports, such as central intake.

At present, the NL health system is characterized by a mix of centralized and decentralized management of services. Some programs have a provincial mandate with a single institution in charge of coordination across all RHAs, while other programs are managed exclusively on a regional basis. As a result, there can be inequitable access (rural) to some programs – long wait times in one region and lower wait times in another for the same service – and also duplication of services if there is over-capacity in one region and stretched capacity in another. This situation is a lost opportunity for cost savings, improved access and quality of care. For example, Labrador doctors noted that they would prefer referring patients to a central intake for specialties in multiple locations in the province, with their patient getting service at the place with the lowest wait time, rather than having to select one location over another with the risk of extended wait times.

In the short term, we recommend: 1. Establish a working group to develop a list of additional services that can be managed provincially; and, 2. Develop the required clinical management systems to support central intake across all RHAs and within sub-specialties.

In the medium term, we recommend: 1. Engage physicians in the roll-out of provincially managed services; 2. Develop and implement a public/patient education program; and, 3. Implement recommendations of the working group.

In the long term, we recommend evaluating for impact on patient care, access, cost savings and provider and patient satisfaction.

6. Accountability

Patients, taxpayers and health stakeholder groups value the role of government, but often question how some investment decisions are made regarding new facilities, technology and services. Most decisions are based on appropriate evidence, but some are driven by non-health criteria. Therefore, our recommendation is that future investments in capital and new health services be reviewed in advance by an independent, expert body that will make recommendations to Government and the RHAS as appropriate.

The decision-making process for new investments in public health care is highly complex, often opaque, and carries significant risk if it results in inefficient allocations of capital. If positive and transformational decisions are made now, as part of Government's fiscal review, then some mechanism is needed to ensure that future decision-making does not erode these efficiency gains. We need to have confidence that the best evidence is being applied to future investment decisions in health care, consistent with health care criteria, and equitable to all regions of the province.

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In the short term, we recommend: Government design and establish an independent expert body to provide an advance review of the annual health capital budget (departmental and RHAs), including the establishment of new or expanded health services, and to make all such budgets and reviews/recommendations available to the public. Using this approach, capital budgeting remains under the control of Government and the RHAs, but before it is submitted for approval to the House of Assembly it is subject to independent review. In the medium and longer term, this approach should be monitored and evaluated for effectiveness and public satisfaction.

Other Related Matters

There are three other related matters that came forth in the consultations that we bring to the government's attention.

1. Future of NLCHI

The NLMA understands from publicly available information that the NLCHI is a candidate for merging into a proposed new shared services agency. This agency will provide support services such as accounting, procurement, human resource management, and information technology to the four RHAs. We believe there is a considerable risk that absorption of the NLCHI into the shared services agency will relegate the distinct role of NLCHI to the background. Understandably, the focus of management of the new agency will likely be driven by the day-to-day exigencies of the four RHAs, and a priority in the initial years will be realizing the savings goals for the new agency, while implementing all the associated and complex change management activities. The NLCHI is not central to the operational requirements of the four RHAs, but it is absolutely central to physicians and the establishment of the Electronic Medical Record (EMR) system. We believe that eliminating or diverting NLCHI's management attention or priority from the successful rollout of the EMR program will be harmful. Moreover, the EMR is not being established only for the 30 to 40% of physicians who are salaried doctors with RHAs; it is even more critical to link up the 60% or more physicians who operate as independent businesses in the community. We recommend that NLCHI remain as a separate entity in the health system to continue its strategic role, of which EMR is a significant part.

2. Health Promotion

The promotion of healthy eating and exercise in the population, especially with school-age children, is essential for long-term sustainability of the health system. While health promotion strategies are long-term by nature, and it may be hard to calculate savings in a three to five-year fiscal forecast, it would be folly not to lay the basis for longer term improvement in the health of the population. Measures to teach nutrition and create exercise habits in young people that have lifelong effects will not only stabilize health care costs, they will produce a more creative and productive population.

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3. Physician Recruitment and Retention

The problem of rapid turnover of physicians in this province, especially in rural areas, requires urgent attention. We can point to several types of cost savings that will occur with better recruitment and retention (lower recruitment costs, lower locum costs, better patient-physician attachment resulting in lower use of specialists and tests). It will also produce equitable care for the rural populations. The NLMA believes that the health human resource plan developed pursuant to a role delineation framework must include measures that have a direct and meaningful impact on our ability to recruit and retain highly trained physicians.

In closing, we wish to thank you for your consideration of our recommendations and for the very positive relationship that we enjoy with Government. The NLMA wishes to partner with Government in the further study and implementation of these recommendations, and we are prepared to provide reaction or advice on any other matter that Government may be considering.

Best regards,

Jonathan Greenland, MD, FRCPC
President