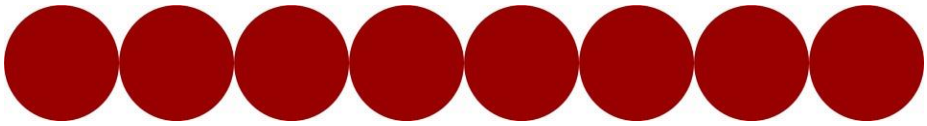
NEWFOUNDLAND AND LABRADOR
MEDICAL ASSOCIATION

Health Care System Redesign Framework Feedback



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Health Accord NL

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The Newfoundland and Labrador Medical Association (NLMA) represents the interests of the medical profession and advocates on behalf of all patients for quality improvements to the health care system. We serve as the voice of almost 1,500 practicing physicians who work in hospitals, community clinics, long-term care facilities and academic settings. Our mission is to represent and support a united medical profession and to provide leadership in the provision of excellent health care in Newfoundland and Labrador. Consequently, we focus on the largest systemic issues facing health care and consult with government on problems with the broadest possible impact on patients throughout the province.

1.0 Executive Summary

The NLMA commissioned an extensive consultation process with physicians to determine their perceptions of the Health Accord's proposed framework for health care system redesign. It is clear from the consultation process that physicians have mixed views on the proposed framework. On the one hand, there is recognition that there is a need to change the current system and the proposed framework could lead to improved efficiency through the centralization of services, as well as better access and quality of care. The focus on team-based primary care in the proposed framework is also seen as a needed change. On the other hand, there is concern that the proposed changes, particularly with respect to the reorganization into three (3) regional hospitals, seven (7) community hospitals, and 13 emergency health centres will negatively impact access to and quality of care. The following is a summary of the key thematic concerns physicians raised with the proposed framework.

Human resources. Physicians repeatedly expressed questions and concerns regarding where the health care providers, physicians and others, would come from to implement the model. They noted there is a shortage of family physicians as is, and it is difficult to foresee how a sufficient complement of family physicians and other health care providers could be recruited and retained to ensure the implementation and sustainability of the proposed framework. As such, there was a call for a detailed human resource plan, including a recruitment and retention strategy, for health care providers. Of particular consideration, is how health care providers would be recruited to and supported in rural and remote areas.

The proposed reduction of services in certain locations was also viewed as compounding the recruitment challenges. It was noted that family physicians want to practice in an environment where there are supportive services in place, including surgery and emergency services. Removing these services in certain locations was viewed as a deterrent to family physician recruitment.

System capacity. Current system limitations with respect to inability of the current emergency rooms to handle volumes made it difficult to see how shifting emergency services to more limited locations would be feasible. Similarly, the capacity of the ICUs as well as OR time were also noted as areas of concern with the consolidation of these services within the regional hospitals and tertiary hub. They noted that there clearly would have to be some redesign to allow these sites to effectively manage the volume increase.

Lack of detail. A segment of physicians participating in this consultation found it difficult to assess whether the proposed framework was the right one due to insufficient detail. While the framework is intended as a higher-level overview, many wanted additional detail about how it would be implemented, particularly how various sites would be impacted, before making the decision about whether to support such a framework. Indeed, given current system challenges with capacity and the ability to recruit physicians, as described above, many wanted to understand how those issues would be addressed.

Reduced access for rural and remote areas. While the proposed framework encompasses enhanced team-based community health care, many felt that there would be reduced access to rural and remote areas. This relates more so to access to acute care services such as testing, surgery, and specialists. There is concern that having to travel a further distance for such services will result in the public not seeking care. Travelling further for care has a number of implications including out-of-pocket patient costs for travel and accommodations, removing people from their support network closer to their community, and the need to take time from work to travel for care.

Timeliness/access to emergency services. The proposed framework's impact on the timeliness of access to emergency services was a prevalent theme throughout the consultations. With a reduced number of emergency departments, and the reduced supportive services (e.g., surgery) in local areas, there was a commonly expressed concern that the risks for negative outcomes, including loss of life, in emergency situations will increase.

Even with an improved emergency transportation system, including advanced care paramedics and air ambulances, it was often felt that the weather conditions in the province would hinder transportation, and thus could not be relied on consistently to provide expedient emergency care.

2.0 Introduction

The NLMA supports the mission of Health Accord NL to transform health care. The NLMA represents the views of physicians of the province and considers it critically important that the voice of its members is reflected in the redesign of the health care system.

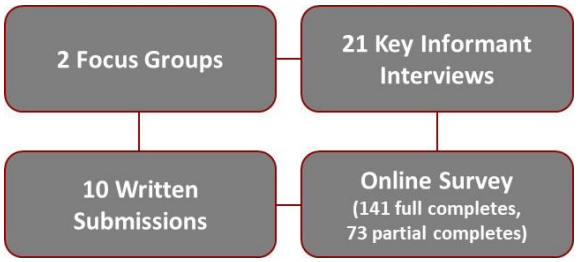
In the winter of 2021, the NLMA conducted a series of consultations with its members along with a member online survey to help inform the development of five (5) briefs that were submitted to each of the Health Accord's Sub-Committees.

With the subsequent release of the Health Accord's proposed framework for health care system redesign, the NLMA felt it prudent to once again reach out to its members to ensure their views and perspectives regarding the proposed restructuring were documented and submitted to the Health Accord for its consideration. To ensure the perspective and experiences of NLMA members are reflected, an extensive consultation process with physicians was undertaken. It did so via multiple channels including focus groups, one-on-one key informant interviews, written submissions, and an online survey.

This document presents the perceptions of physicians, as detailed through the extensive consultation process.

3.0 Methodology

As noted, a multi-modal approach was used to consult with physicians. This allowed for multiple opportunities for physicians to provide input through their preferred means. Consultations took place in July and August of 2021. The following summarizes the engagement of physicians in this consultation.

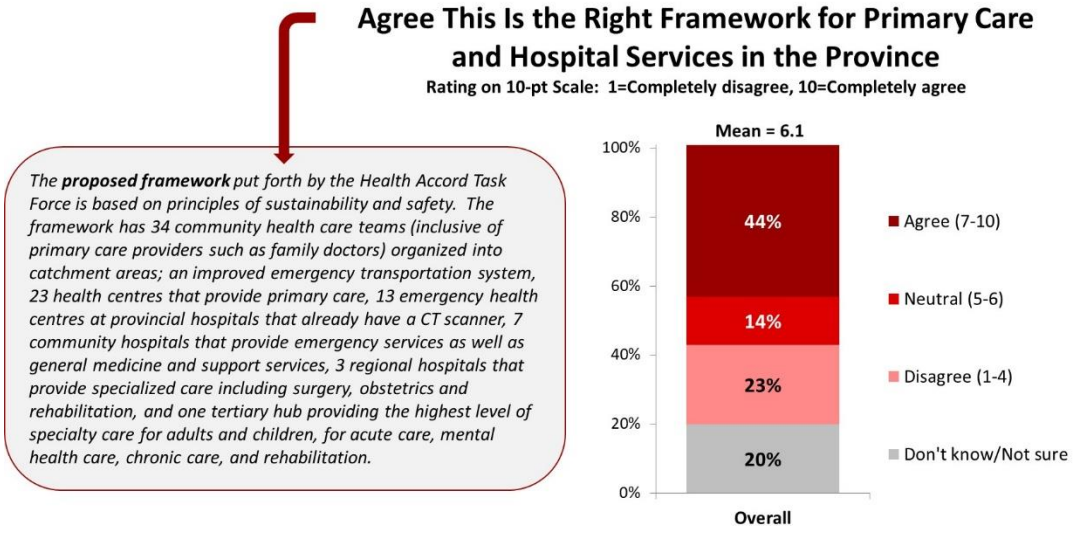


4.0 Key Findings

4.1 Response to Proposed Framework

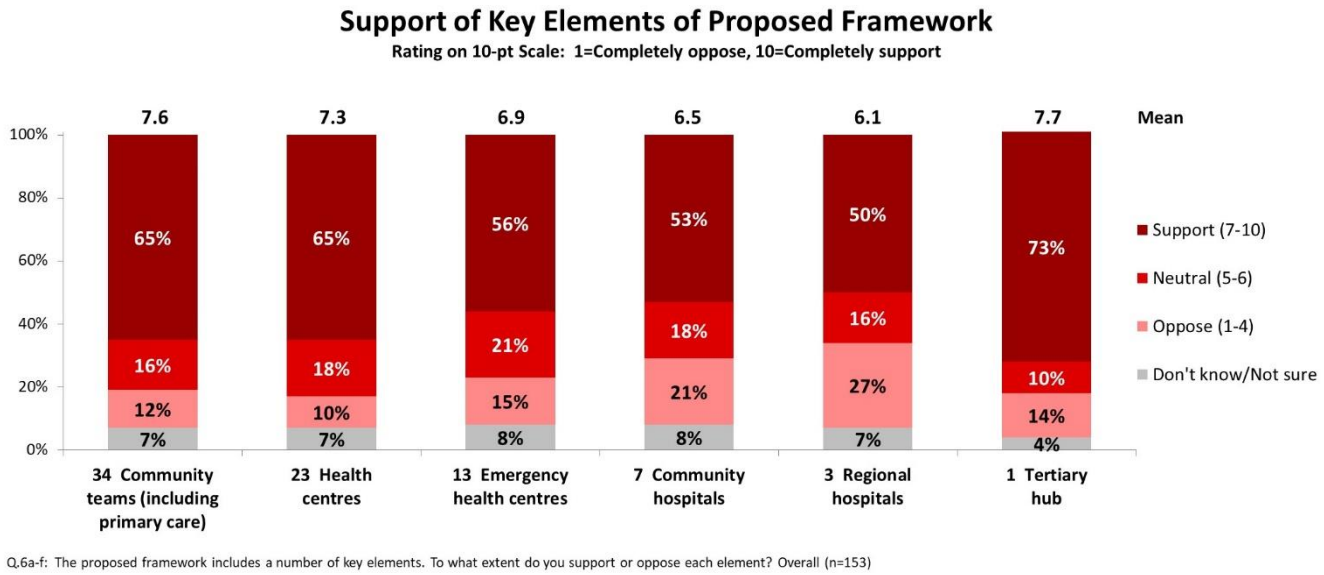
Overall Reaction

Physicians exhibited mixed reaction to the proposed health system redesign. Irrespective of level of support for this model, physicians widely acknowledge that the current system is not sustainable nor is it achieving the health outcomes desired. Survey results illustrate the conflicting views of the proposed model. Just over four in ten physicians responding to the survey agree the framework for primary care and hospital services is the right one, while one-quarter disagree. The average level of agreement is modest at 6.1, but reflects that agreement outweighs disagreement. One in five physicians refrain from providing an opinion at this time, likely reflecting the desire for more details in assessing the proposed framework. It is important to note that disagreement (providing a rating of 1-4) is elevated among physicians in rural locations (35%) compared with those in urban locations (15%).



Q.1: All things considered, to what extent do you agree or disagree that this is the right framework for primary care and hospital services in the province?
Overall (n=214), Family Physician (n=90), Specialist (n=83), Urban (n=127), Rural (n=83)

While support for the overall framework was modest, there is stronger support for specific aspects. Survey results indicate the most widely supported (rating of 7 to 10 on the 10-point agreement scale) is the tertiary hub, with three-quarters of physicians responding to the survey supporting this aspect. Two-thirds support the concepts of 34 community teams and 23 health centres. Less widely supported, albeit supported by a slim majority, are the concepts of 13 emergency health centres, seven (7) community hospitals, and three (3) regional hospitals.



Q.6a-f: The proposed framework includes a number of key elements. To what extent do you support or oppose each element? Overall (n=153)

While the majority support the establishment of community health teams, it is noteworthy that family physicians (55%) are slightly less supportive than specialists (67%). Another distinction to note is that rural physicians (37%) are much less supportive of the concept of three (3) regional hospitals than are urban physicians (60%) and to some degree, the 13 emergency health centres (49% rural support vs. 61% urban). While numbers are small and thus interpretation warrants caution, IMGs are less supportive of community teams (53%) than others (68%).

Thus, it seems that physicians are in favour of the end points of the system – community teams and health centres on one end and the tertiary hub on the other, but are more hesitant or concerned about the realignment of emergency health centres and community and regional hospitals.

Reasons for Framework Support

> "Primary care needs to be the backbone of the health care system. Sustainable community teams, properly distributed is critical. Regionalizing hospital services will ensure sustainability of those services and will stabilize the physician workforce."

One of the primary reasons for support of the framework was a much-needed **focus on primary health care**. For the most part, the concept of community teams was well-received, based on the premise that every resident of the province having consistent and timely access to a family physician. Many physicians reference the family physician shortage in the province and the importance of having a strong primary care system to the success of this proposed framework. Having consistent, longitudinal, timely access to a primary care provider is seen as critical to a healthy population and to reducing the pressures on the acute care system.

It merits highlighting that some specialists report that due to the family physician shortage, they are providing primary care to some of their patients. This was not seen as an efficient use of resources, with some noting they could reduce their wait list by approximately one-quarter if these patients had access to a family physician.

Similarly, a few specialists report there are many acute care admissions for chronic health conditions that, if the patient had timely access to a family physician, their care could have been better managed and an emergency department visit and/or admission avoided. Under this proposed framework, it is anticipated by some that there will be a **reduction in emergency department visits and admissions** as people will be able to access care when required from these community teams.

Having **allied health care professionals** as part of these community teams is also considered a strength. It was noted by several physicians that they are often doing non-physician things or activities that would be more appropriately done by another team member. Having access to allied care professionals would ensure patients are getting the most appropriate treatment by the right provider. Currently, access to these professionals can be limited and involve significant wait times. There are also many other social factors that affect peoples' health besides access to medical treatment. For example, having a social worker as a member of the community team is seen as an asset as the social worker can help address some of these other factors impacting patients' lives (e.g., access to other resources, supports and/or services). In this regard, it is thought that providing team-based care would help support and redistribute the workload of solo family physicians and lead to better outcomes for patients, as they would have more timely access to the most appropriate health professional.

> "At present no health care provider seems to be working to their full scope or efficiency. Primary health care teams will maximize efficiency in routine care and can focus on prevention rather than mainly reactionary care. This will improve downstream resource use for specialty and subspecialty care. As a specialist…I am providing a lot of primary care because of the deficits in our current system, which limits my reach to the population…who need a specialist approach."

> "It must be taken into account how old the population is - this is a very geriatric population - we need numerous publicly funded podiatrists, physiotherapists, dieticians, occupational therapists, audiologists, diabetic educators in every primary health care region - there should be enough of these allied health care professionals to ensure short wait times and to ensure that primary care is a multidisciplinary care model vs. a solo physician care model."

> "Specialty services are too spread out. Volume/outcome matters in surgery and thus we need to create centers with enough volume to allow good outcomes. Low volume centers likely provide poorer outcomes, although we don't know this as surgical outcomes are not measured."

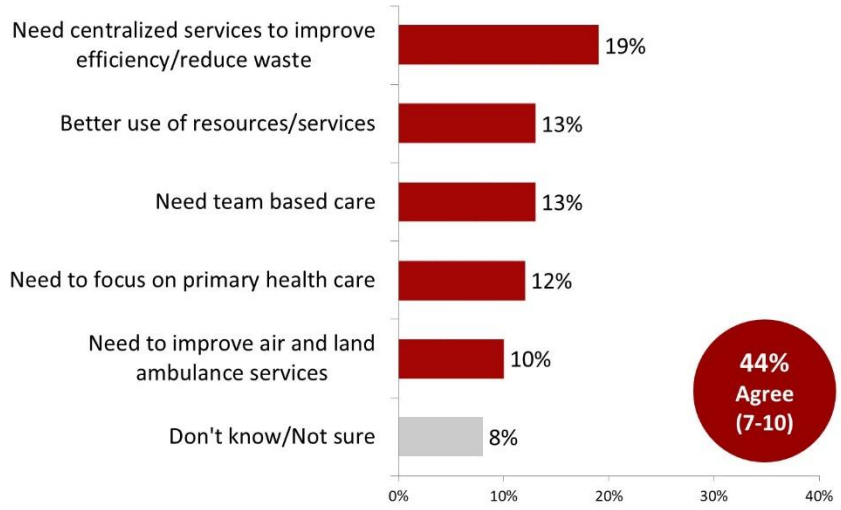
> "Working together in groups likely leads to greater patient here and greater professional satisfaction. I think it will help with the retention of family physicians given the other physicians to collaborate with."

Some physicians who participated in the interviews highlighted the proposed framework could lead to **increased collaboration within a patient-centred model** of care and this would be beneficial for both patients and professionals. They also saw opportunities for maximizing efficiency and improving quality of care by **centralizing certain services**, such as laboratory services, pathology, health record and file management, with increased use of technology, proven effective as evidenced by the pandemic experience. Many noted centralization, particularly for non-urgent care, facilitates more efficient and cost-effective delivery of service, and allows for sufficient volume for physicians to maintain skills and competency levels.

Survey results echo these sentiments. Those agreeing that this is the right framework state a need for centralized services to improve efficiency and reduce waste, that it is a better use of resources, and that team based and primary care is needed, as is improved air and land ambulance services.

Reasons for 7-10 Ratings With Respect to This Being the Right Framework for Primary Care and Hospital Services in the Province

Unaided Key Mentions Among Those Rating 7-10



Q.2: **[IF RATED PROPOSED FRAMEWORK 7-10 Q.1]** Why do you provide a rating of 7-10 with respect to this being the right framework for primary care and hospital services in the province? (n=83)

Reasons for Framework Opposition or Concern

Amongst those physicians who strongly oppose the proposed framework, one of the key concerns is **emergency medical situations**. These physicians repeatedly expressed concerns that the model would result in emergency care being too far away for many areas, and that consideration needs to be given to what is a safe distance from services. Likewise, general surgery, obstetrical care, and pediatric care were also identified as speciality services that require more thought when

> "This model is not suitable for our geography. Regionalizing surgical services to 3 hospitals is dangerous and will result in completely preventable deaths. Our air ambulance service does not serve rural areas well as it is understaffed and underequipped. I strongly feel that this model would significantly increase the already present rural inequity that exists within our province."

identifying alignment and transfer of services from one facility to another. While system costs are seen as a driver of change, standards and quality of care, medically appropriate outcomes, and improvements in service delivery cannot be ignored.

While the proposed model would rely on enhanced paramedic care and ambulance services, it was felt that the **geography, combined with weather, would render this enhanced paramedic care and ambulance services ineffective** as travel via land or air would be hindered by weather conditions. Even without the issue of weather, the anticipated distances to emergency care were perceived to be too far and road/highway conditions less than ideal (paving, icing, snow removal, etc.).

> "Geographical considerations will make speciality service necessary in some areas. Upgraded transfer/ambulance services are not the answer due to unpredictable weather."

There is also concern that the consolidation of services into the regional hospitals and the tertiary site will actually result in longer wait times to access services due to **physical infrastructure constraints** (i.e., lack of beds and OR time). It was noted that the current emergency room (ER) system at the Health Sciences Centre is currently working at, or exceeding capacity and there are existing issues with both the emergency department and the transfer of patients from other regions. Thus, redirecting more emergency care to the Health Sciences Centre is not feasible without significant changes/enhancements.

> "The right idea would be to keep tertiary centre only for complicated stuff and have at least five hospitals to provide efficient services for the population. The total population of NL is around 500,000 and three regional hospitals for routine surgeries will not be sufficient. Have you calculated the waiting times for the surgeries in the three regional hospitals?"

Increased travel times and the associated costs for patients are also identified as obstacles in the implementation of this proposed framework. There is concern that patients will put off seeking medical attention, especially preventative health measures, such as cancer screening, as a result of these increased travel times and costs. It is thought that this will be more pronounced in rural and remote areas as well as amongst the elderly, and thus create a greater inequity of services. It is believed that this will result in patients presenting with more advanced stages of disease as opposed to early detection.

> "I cannot see how one tertiary center will be able to service all of NL for said issues such as mental health, chronic disease and rehabilitation. How are residents of our province going to be able to afford to travel to said tertiary center? Same goes with the 'three' hospitals providing obstetrical and surgical services. I feel that this model may not be conducive to the structure of our province and will disadvantage rural communities who already have significant difficulty accessing health care. Not to mention where are our CLINICAL family doctors to support this structure?"

The framework was also criticized for not providing sufficient detail regarding **what financial supports will be in place to assist patients** attend non-emergent medical appointments from their home communities as a result of having to travel greater distances to obtain care.

Despite the value associated with community teams, some expressed concern regarding the **recruitment and retention** of these team members, most notably in more rural and remote areas. While the team-based care model may be attractive to some, historically it has been challenging to recruit and retain health care providers in these areas. Furthermore, some physicians suggested that the proposed restructuring could further hamper recruitment and retention efforts. For family physicians, practicing in rural sites with limited access to local supports, most notably specialist care, was seen as significant drawback. From the specialist perspective and within the context of the physical infrastructure of the proposed regional hospitals and tertiary centre, there will be limited access to operating room (OR), clinic and/or other diagnostic procedure times. This will make these sites less attractive for recruitment and retention purposes. Indeed, it was felt that the framework, in its focus on community teams, needs to emphasize the importance of human resource planning for physicians (family medicine and other specialities) as well as the need for the other required allied health professionals (social workers, physiotherapists, nurses, dietitians, etc.).

> "Has the government outlined the plans to recruit staff into the positions to run these services? Without the government outlining how they will deal with areas of concern such as recruiting of medical personnel e.g., doctors, I don't think this will be implemented successfully."

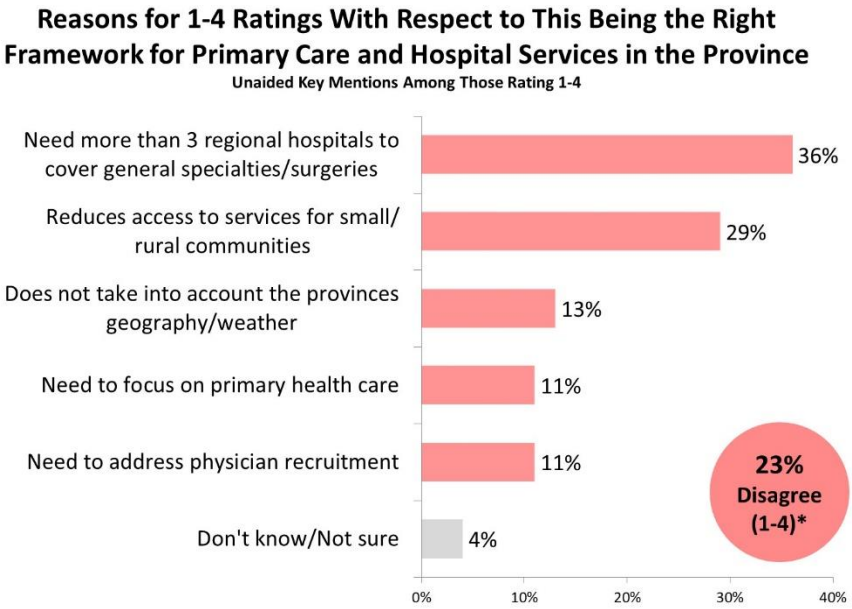
> "While in theory the proposal reads well when going through the framework, it is how this will work within the real constraints for your current system that lead me to give this a low score. Without knowing how are we going to staff these wonderful teams that the proposal talks about, they seem too unrealistic of an expectation. We already cannot get a sustainable work force in many of the smaller areas and I do not realistically think these teams will be functional. Also, I currently work on an interdisciplinary team…and the number one limitation on us working to our full potential is frequent turnover of non-physician team members such that we can never get to the specialized level that was proposed as the physicians are always left holding down the fort so to say, while other positions are empty or people are orienting or learning their role. So, while I like the ideas put forth, I would need more info on how it would materialize before I can think of it as a positive move forward."

In addition, physicians also raised the following questions/concerns regarding the establishment of community teams:

- Would the teams be co-located? If so, some community-based family physicians expressed concern regarding the current restrictions of their current office space.
- What are the mechanics of employment including who will be employing the team members, providing benefits and carrying the necessary insurance?

- What would be the reporting structure within the team? Would there be a manager?
- What would be the communication structures?
- How would patient information be shared? What are the logistics around EMR usage?
- Do both the provider and the patient have to reside in the same catchment area?
- Will the community teams be able to handle the volume of patients in the area? The concept is to ensure everyone has primary care and thus it is important that this actually happens in practice.
- Will there be flexibility to accommodate differing population/regional needs?
- Will the compensation model encourage a collaborative team-based approach as the current model and fee codes currently do not? Are physicians in practice expected to cover the costs of a community team as part of their overhead?
- Are community teams looking at the whole life cycle, from infants and children to adults and seniors?
- Physicians often take on the role of system or patient navigator. How will this role be managed within the community team model?
- While the catchment area concept is seen as appropriate for rural parts of the province, how will it be applied within the context of the St. John's population?

In the survey, the top reasons for disagreeing that this is the right framework include needing more than three (3) regional hospitals to cover general specialities/surgeries and concern for reducing access to services for small/rural communities. Other reasons for disagreement include that it doesn't take into account weather and geography and doesn't address physician recruitment. There is also acknowledgement that there is a need to focus on primary health care.

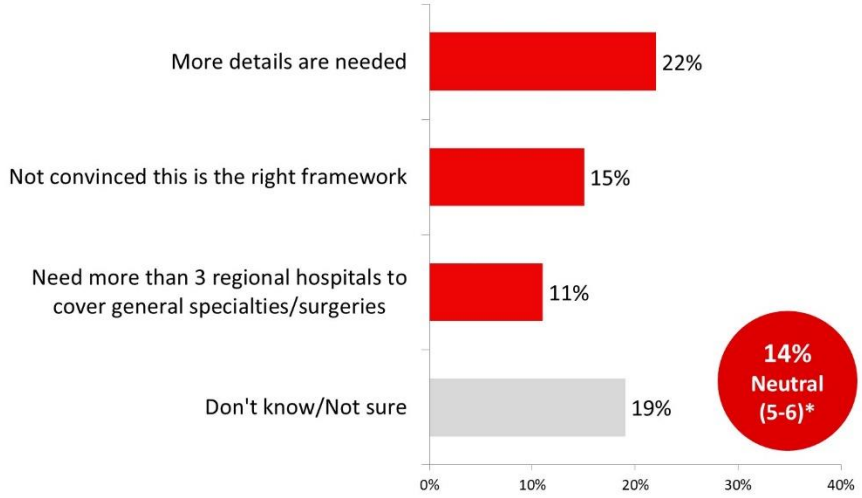


Q.2: **[IF RATED PROPOSED FRAMEWORK 1-4 Q.1]** Why do you provide a rating of 1-4 with respect to this being the right framework for primary care and hospital services in the province? (n=45*)
**Caution: Small sample size.*

Those providing moderate ratings (n=27) on the survey reflect a desire for more detail, uncertainty, and a concern that three regional hospitals are insufficient.

Reasons for 5-6 Ratings With Respect to This Being the Right Framework for Primary Care and Hospital Services in the Province

Unaided Key Mentions Among Those Rating 5-6



Q.2: **[IF RATED PROPOSED FRAMEWORK 5-6 Q.1]** Why do you provide a rating of 5-6 with respect to this being the right framework for primary care and hospital services in the province? (n=27*) **Caution: Small sample size.*

Similarly, many physicians who participated in the interviews also expressed concern with the lack of detail regarding the proposed framework's implementation. Indeed, many physicians expressed a reluctance to get behind the framework without knowing implementation details. They found it difficult to support a framework without a clear understanding of how it would be implemented. More specifically, they highlighted:

> "It sounds good in theory, but hesitant until seeing how it would be distributed in reality and want to ensure it doesn't lead to more restricted health care access to some with transportation challenges."

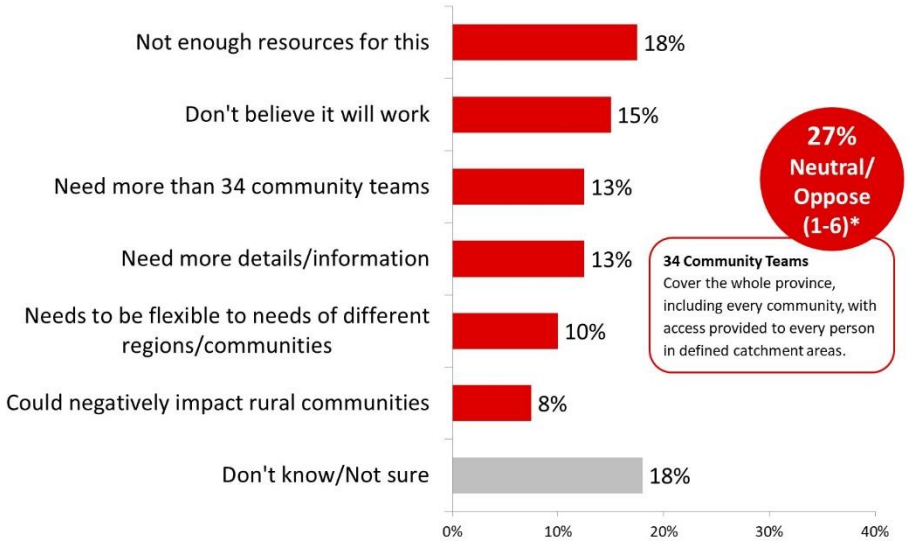
- Not all the factors have been considered in the decision-making process and certain decisions have been made based on incorrect assumptions, most notably with respect to the province's ability to recruit and retain physicians.
- There is a need to have a better understanding of what sites/services will be affected.

Those rating each of the aspects of the framework as less than seven (7) were given an opportunity to comment on their ratings. The reasons provided echo the concerns identified above.

With respect to the 34 Community Health Teams, insufficient resources, not believing it will work, a need for more than 34 community centres, a need for more details, a need to be flexible to differing needs of regions/communities and a concern for the potential negative impact on rural communities were cited as areas of concern.

Reasons for 1-6 Ratings With Respect to 34 Community Teams

Unaided Key Mentions Among Those Rating 1-6

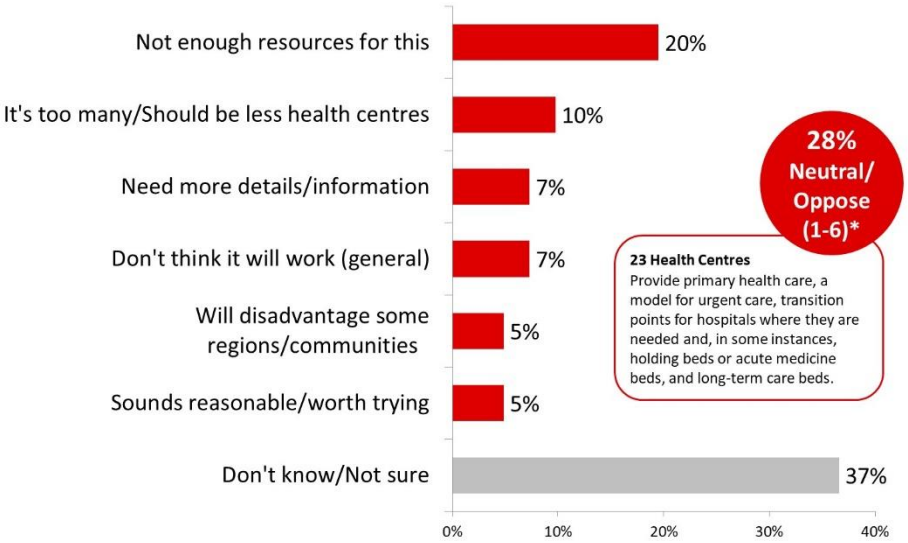


Q.7a: **[POSE IF Q.6A<7]** Why do you rate [Q.6A - 34 community teams (including primary care)] as '[RESPONSE FROM Q.6A]' on the scale of 1 is 'completely oppose' and 10 is 'completely support'? (n=40*) **Caution: Small sample size. ~Due to rounding.*

For the 23 Health Centres, again, insufficient resources was the top reason for a lower rating. One in ten mention it is proposing too many health centres.

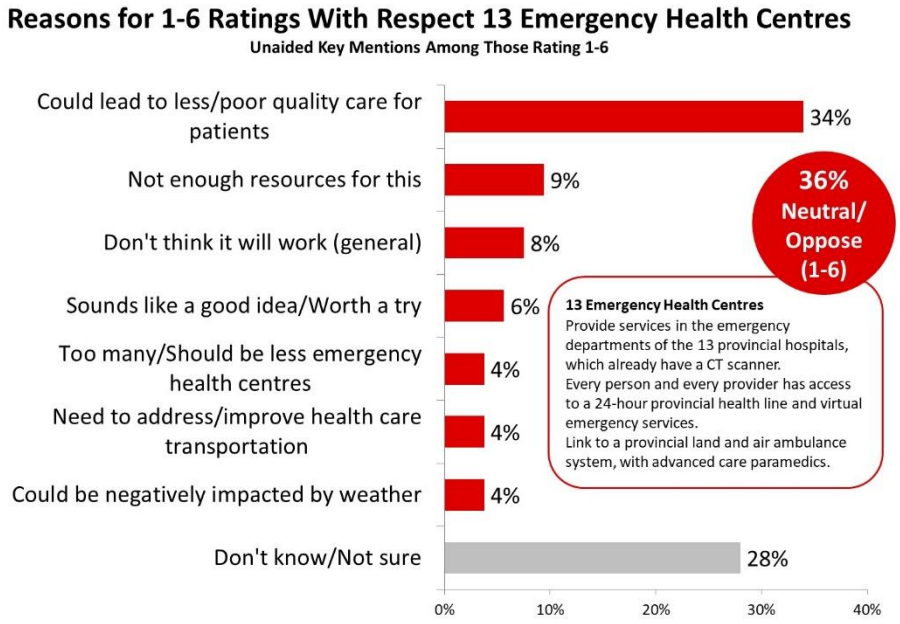
Reasons for 1-6 Ratings With Respect to 23 Health Centres

Unaided Key Mentions Among Those Rating 1-6



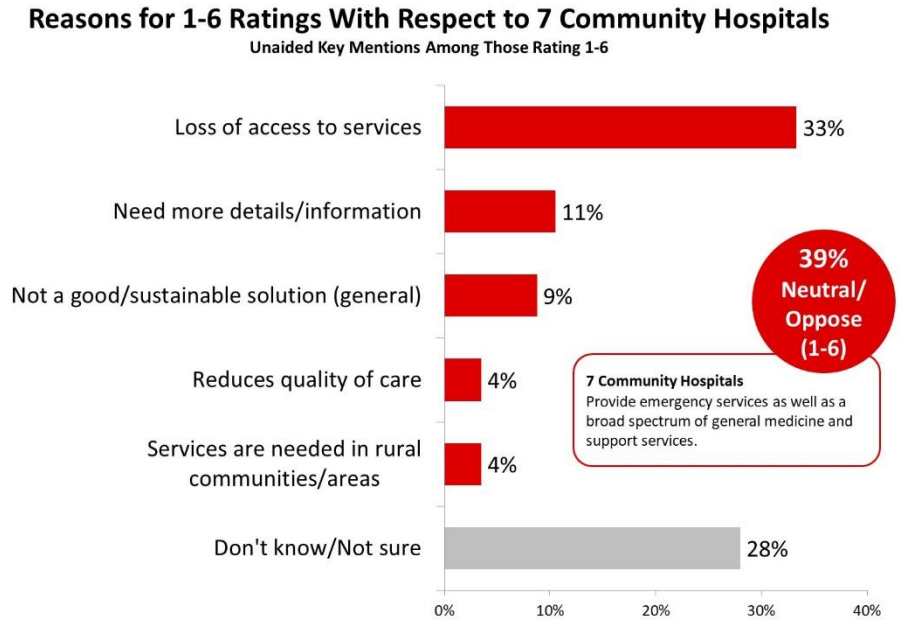
Q.7b: **[POSE IF Q.6B<7]** Why do you rate [Q.6B - 23 health centres] as '[RESPONSE FROM Q.6B]' on the scale of 1 is 'completely oppose' and 10 is 'completely support'? (n=41*) **Caution: Small sample size.*

For the 13 Emergency Health Centres, the primary concern is the potential for poorer quality care.



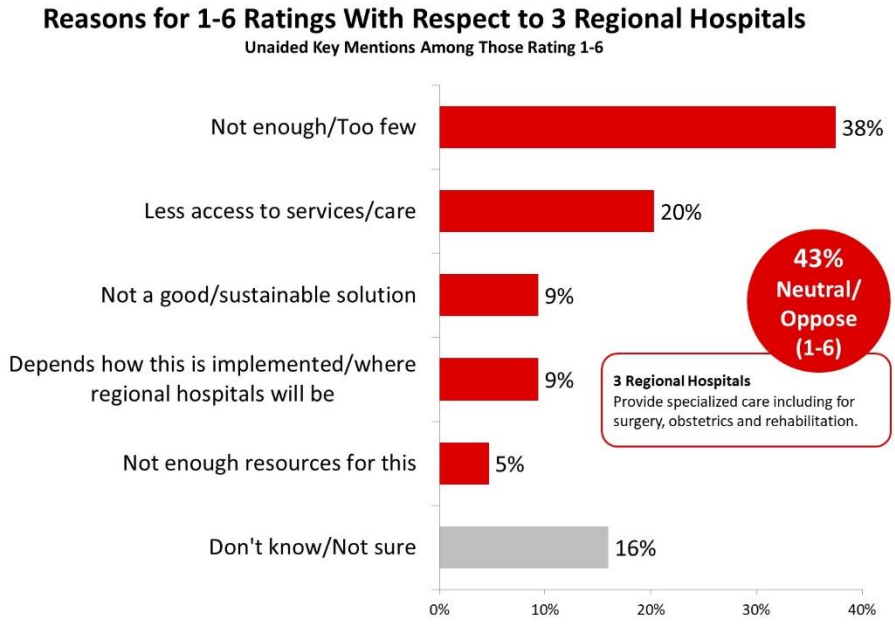
Q.7c: **[POSE IF Q.6C<7]** Why do you rate [Q.6C – 13 emergency health centres] as '[RESPONSE FROM Q.6C]' on the scale of 1 is 'completely oppose' and 10 is 'completely support'? (n=53)

Loss of access to services is the key concern with respect to having seven Community Hospitals.



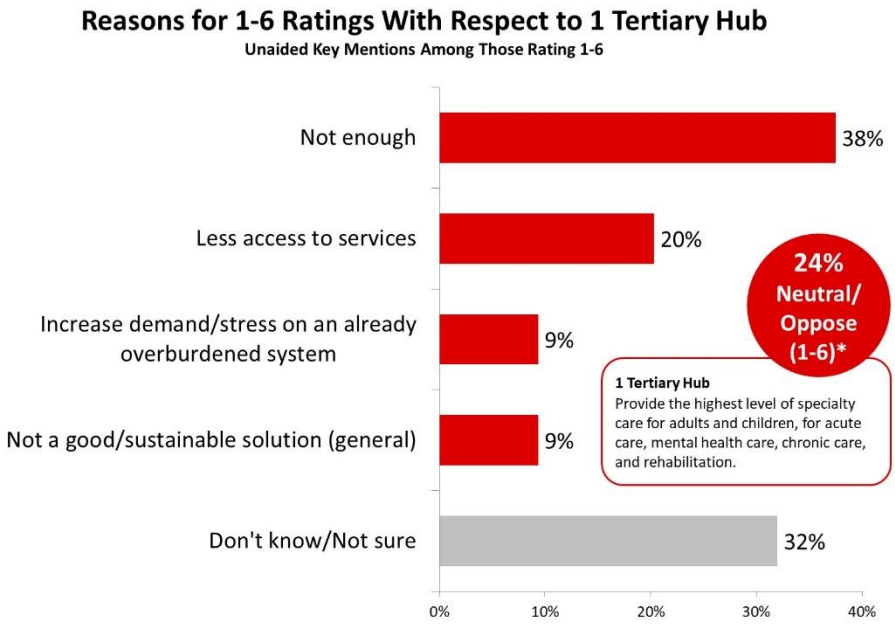
Q.7d: **[POSE IF Q.6D<7]** Why do you rate [Q.6D – 7 community hospitals] as '[RESPONSE FROM Q.6D]' on the scale of 1 is 'completely oppose' and 10 is 'completely support'? (n=57)

Those providing a rating of 1 to 6 for three Regional Hospitals most frequently noted that three was too few, followed by a concern for the lower access to services.



Q.7e: **[POSE IF Q.6E<7]** Why do you rate [Q.6E – 3 regional hospitals] as '[RESPONSE FROM Q.6E]' on the scale of 1 is 'completely oppose' and 10 is 'completely support'? (n=64)

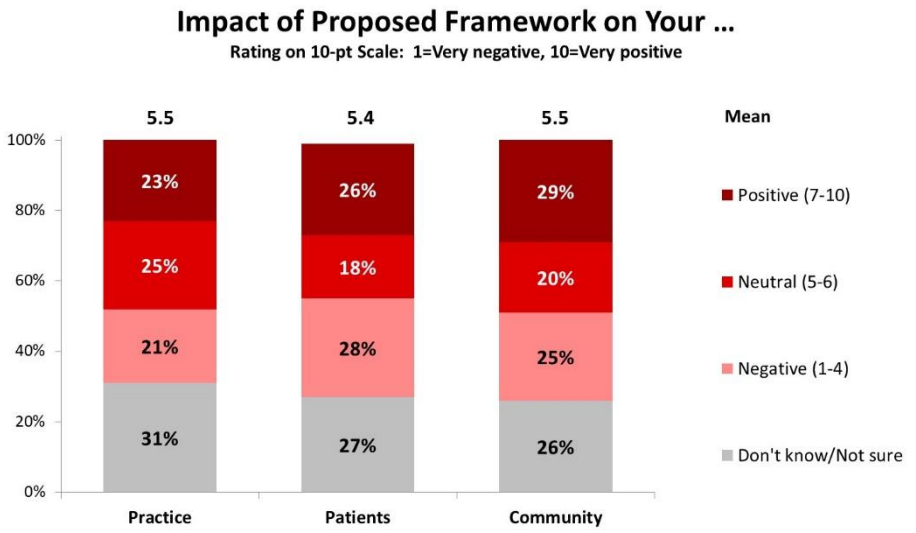
Finally, among the one-quarter of survey respondents less supportive of one Tertiary Hub, one not being enough was the key reason offered, followed by less access to services.



Q.7f: **[POSE IF Q.6F<7]** Why do you rate [Q.6F – 1 tertiary hub] as '[RESPONSE FROM Q.6F]' on the scale of 1 is 'completely oppose' and 10 is 'completely support'? (n=34*) **Caution: Small sample size.*

4.2 Impacts of Proposed Framework

Consistent with their overall assessment of the proposed framework, physicians were divided with respect to the impact of the proposed framework on their practice, patients and community. In all three instances, the anticipation of negative impacts was notably elevated among rural physicians compared with urban ones. It is also important to note that there is a certain level of uncertainty with at least one-quarter of physicians indicating they are uncertain about the impacts.

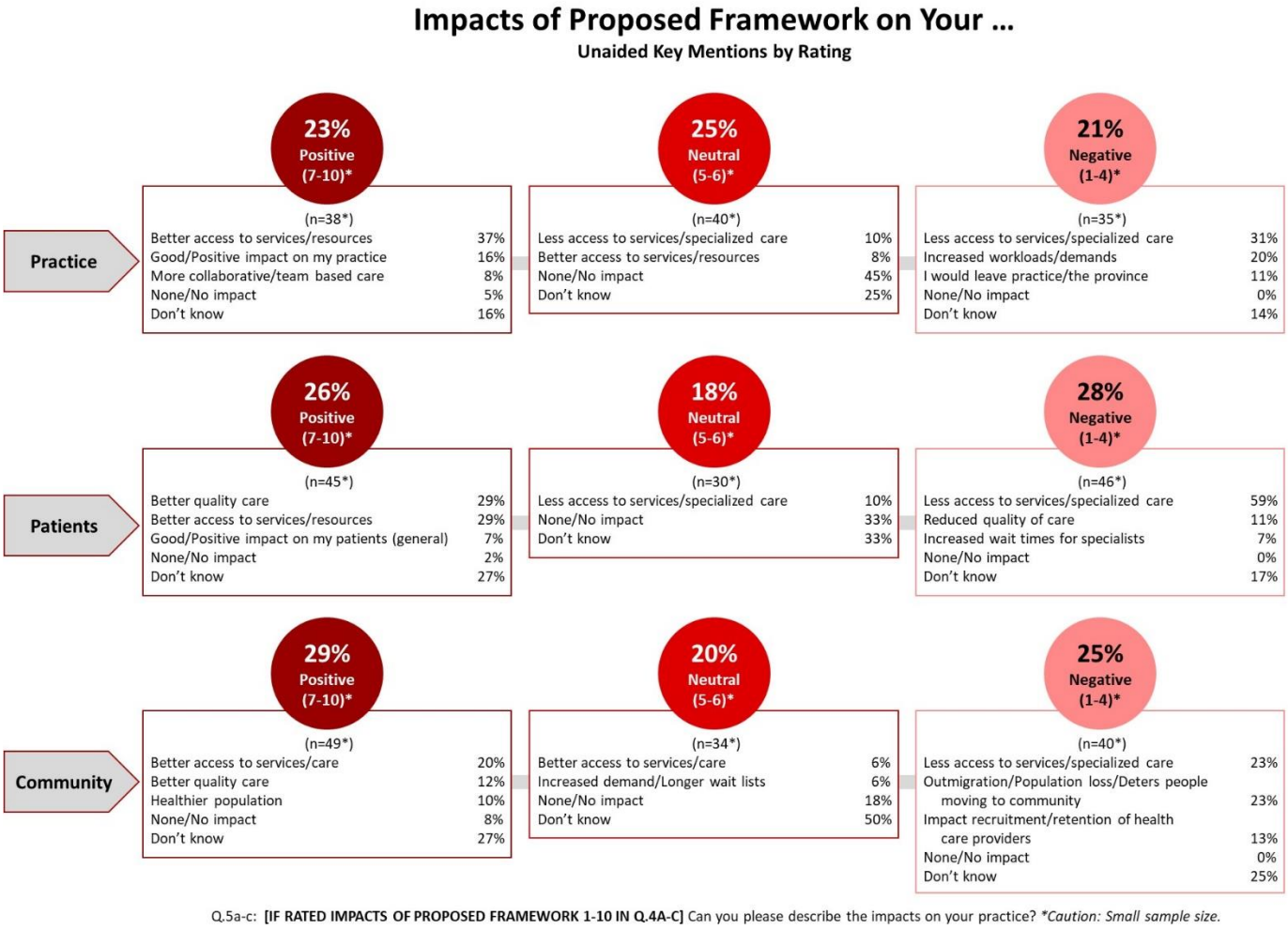


Q.4a-c: What impact would this proposed framework have on? Overall (n=173), Family Physician (n=76), Specialist (n=68), Urban (n=98), Rural (n=71)

Those anticipating positive impacts indicated there would be **better access to services/resources**, as well as **better quality care for their patients and community**, and to some extent, **a healthier population** in their community.

Those anticipating negative impacts were primarily concerned with **less access to services/care/distance to services for their patients**, while the potential for **population loss** in their community/region was also noted. In terms of negative community impacts, the **ability to recruit/retain health care providers** and **job loss** were also noted.

Those with moderate ratings of five or six did not identify any particular reasons for their ratings, although those identified did reflect mixed anticipation of negative and positive impacts.



Q.5a-c: **[IF RATED IMPACTS OF PROPOSED FRAMEWORK 1-10 IN Q.4A-C]** Can you please describe the impacts on your practice? **Caution: Small sample size.*

4.3 Decision Making Factors

Throughout the consultations, **distance** and **time to access services**, along with **geography**, **weather** and **human** and **operational** resources were consistently identified as the main factors that need to be taken into account when determining the site locations and the services that will be provided. These factors have been noted and explained in detail in the sections above. In addition to these predominant factors, others noted the importance of taking into consideration the following factors:

- Conduct a thorough analysis of what services have been traditionally offered at each site and the associated usage patterns over time to determine at what capacity they have been operating including whether physicians are able to practice to their full scope and maintain competencies.
- Undertake a comprehensive cost analysis to determine the cost benefit of moving resources and services. This analysis will also need to consider the patient transfer costs as well as the costs of expanding and updating the infrastructure in locations that will remain to address increase volumes. Services should only be moved if there is a net positive gain.

- The stability of the health care workforce in the area and the ability to attract and retain health care professionals over time.
- Specific regional/community needs including:
    - Incidence of comorbidities and the genetic predispositions that are prevalent in some areas of the province.
    - Variations in the aging demographic across the province.
    - Birth rates to determine obstetric services.
- Establishment of performance metrics to determine if the changes made have had the intended impact.

The factors important to decision-making were explored in the survey as well. Physicians were presented with a list (which was developed in part based on the qualitative feedback obtained) and asked to consider the importance of each. Not surprisingly, all are considered important by a solid majority of two-thirds or more. Particularly insightful, however, is the percentage providing a rating of 10 out of 10, indicating a factor is critically important. **Human resources planning/recruitment and retention of health care providers** is most widely considered critically important – by eight (8) in ten. This reiterates the concerns physicians expressed throughout the consultation that the current planning is inadequate, and there are concerns about where health care providers for the future model will be obtained. This is the most widely viewed critically important factor across physician types, location, IMG status, and irrespective of the level of overall agreement with the proposed framework.

> "I think we need to insist on a human resource plan not only for physicians, but for all health professional as part of the reimagining the system. It would be great if we [physicians] could lead on that issue."

Other elements receiving a 10 out of 10 rating by at least one half include patient safety (66%), quality of service (55%), standards of care (55%), capacity of proposed remaining facilities to manage increased volumes (55%), current stability of staffing at health care sites (54%), and health care transportation infrastructure (50%).

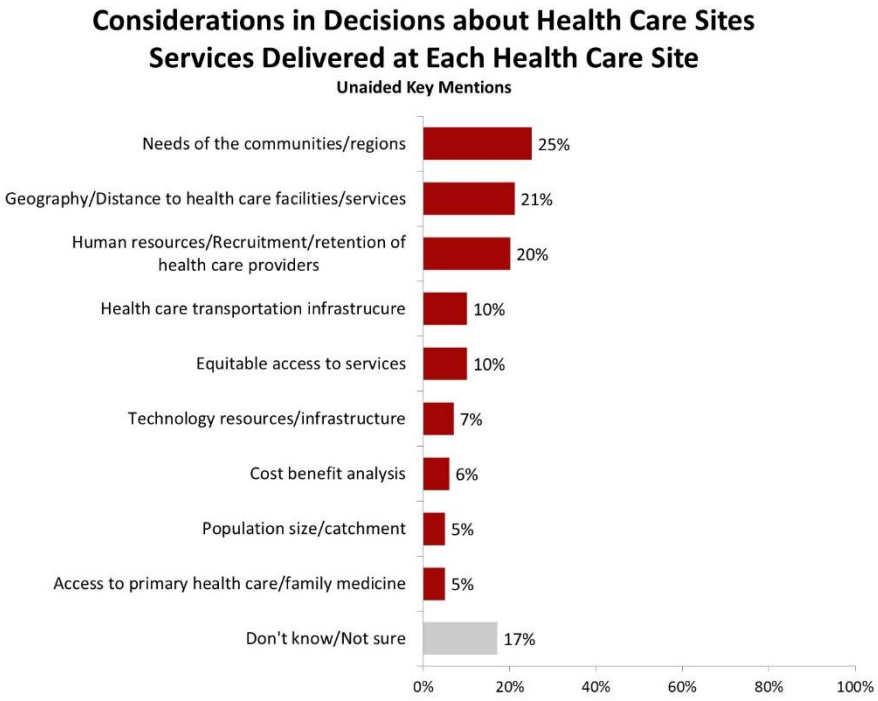
Physicians in rural areas were more likely to give an importance rating of 10/10 compared to those in urban areas to geography/distance to health care facilities, impact of inclement weather on access to services, and out-of-pocket patient travel costs. Those in urban areas were more likely to rate patient safety, cost savings analyses, and costs of maintaining/running specific facilities as 10/10. Family physicians were more inclined to rate physician remuneration models as 10/10 in terms of importance. Specialists were more inclined to rate patient safety, quality of service, standards of care, and heath care transportation infrastructure as 10/10.

Importance of Factors When Making Decision on a New Framework for Health Services

Rating on 10-pt Scale: 1=Not at all important, 10=Critically important	Rating of 10/10	Important (7-10)	Mean
Human resources planning/Recruitment and retention of health care providers (physicians and others)	80%	96%	9.6
Patient safety	66%	96%	9.2
Quality of services	55%	98%	9.2
Standards of care	55%	97%	9.1
Capacity of proposed remaining facilities to manage increased volumes	55%	92%	8.9
Current stability of staffing at health care sites	54%	95%	9.1
Health care transportation infrastructure (ground and air ambulance)	50%	89%	8.8
Physician remuneration models	48%	85%	8.6
Impact of inclement weather on access to services	36%	76%	7.8
Geography/Distance to health care facilities	35%	79%	8.0
Culturally appropriate services for Indigenous populations	30%	72%	7.6
Out-of-pocket patient travel costs	29%	73%	7.6
Cost of maintaining/running specific facilities	27%	72%	7.6
Population size/Catchment area	26%	79%	7.8
Cost savings analyses	24%	67%	7.2

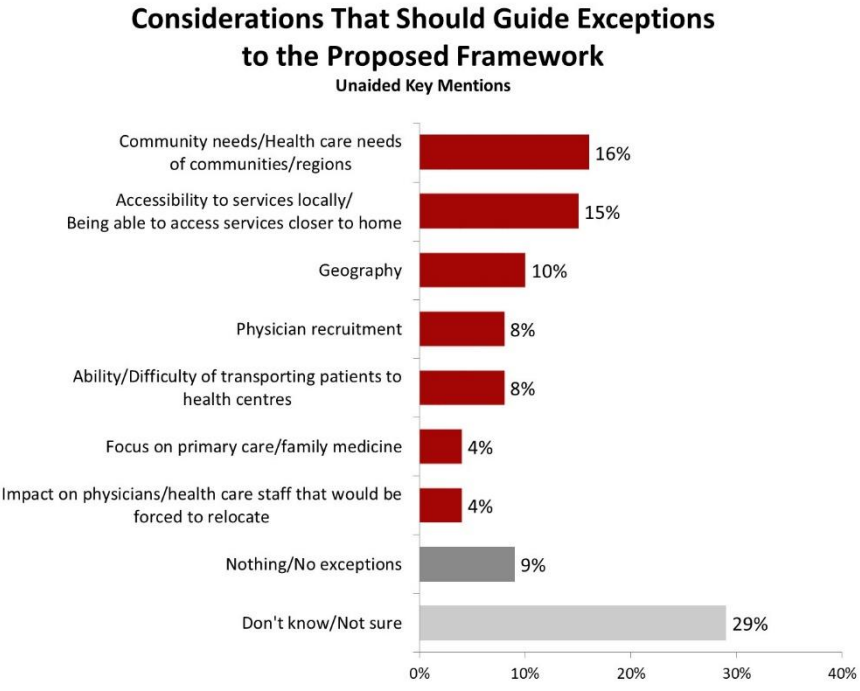
Q.10: How important are each of the following when making decisions on a new framework for health services? While many factors may be considered important, please give higher ratings to the items you feel are most important and lower ratings for the items you feel are relatively less important. (n=141)

Physicians were specifically asked in the survey what needs to be considered in decisions about health care sites and/or services delivered at each of the health care sites. The top three (3) factors mentioned were needs of the community/region, geography/distance to health care facilities/services, and human resources. It merits highlighting that family physicians are three times as likely to identify needs of the community/region compared with specialists (31% vs. 11%). It is also of note that those in opposition to the framework are more inclined to mention equitable access to service (23% vs. 5% of those in favour of the framework).



Q.9: The proposed framework will require decisions about what types of services will be provided at which locations. What needs to be considered in decisions about health care sites and/or services delivered at each of the health care sites? (n=146)

Physicians were also asked in the survey what considerations should guide exceptions to the proposed framework. Again, the needs of the communities/regions were a top mention, as was accessibility to services locally. Other common themes including geography, physician recruitment, and ability to transfer patients to health centres.



Q.3: What considerations, if any, should guide exceptions to the proposed framework? (n=184)

4.4 Success Factors

The factors physicians believe are required for the framework's success echo the concerns and decision-making factors outlined earlier. Perhaps the most critically important factor identified in the consultations to ensuring the success of this model is a **full complement of family physicians** in the province who are well-supported professionally. It was acknowledged that it is difficult to recruit and retain, particularly to rural areas, as physicians do not feel supported, do not have a network, and the burden of on-call can be overwhelming. It was identified that more could be done to ensure students are well-versed in rural practice. There is concern with a reduction of hospital services in these areas that family physician recruitment will become even more difficult.

> "Removing multiple surgical/tertiary services is unwise; there will be many unanticipated consequences. This framework will be problematic for family physicians in rural areas who depend on surgery/surgical services for back up and will further exacerbate our already poor physician retention."

> "Primary care in this province is in crisis and this framework rightly puts the foundation of health care in this province on primary care, but if there is going to be more responsibility on primary care, every patient should have a family doctor, family doctors should be paid in a way that supports complex care where physicians can spend time with their patients so they don't have to go to higher up care centres unless absolutely needed, and primary care needs TIMELY access to specialist services that doesn't put the onus on FPs to take time out of their day to have to track down and call specialists in order for patients to be seen…."

Physicians pointed to the need for a **funding model for family physicians that recognizes quality of care, leadership roles, and team approaches.** It was widely felt the current FFS model does not recognize the complexities involved in a team-based community health approach, and thus the funding model needs to be revamped to support this approach. It was recommended that a capitation or a blended payment model be considered.

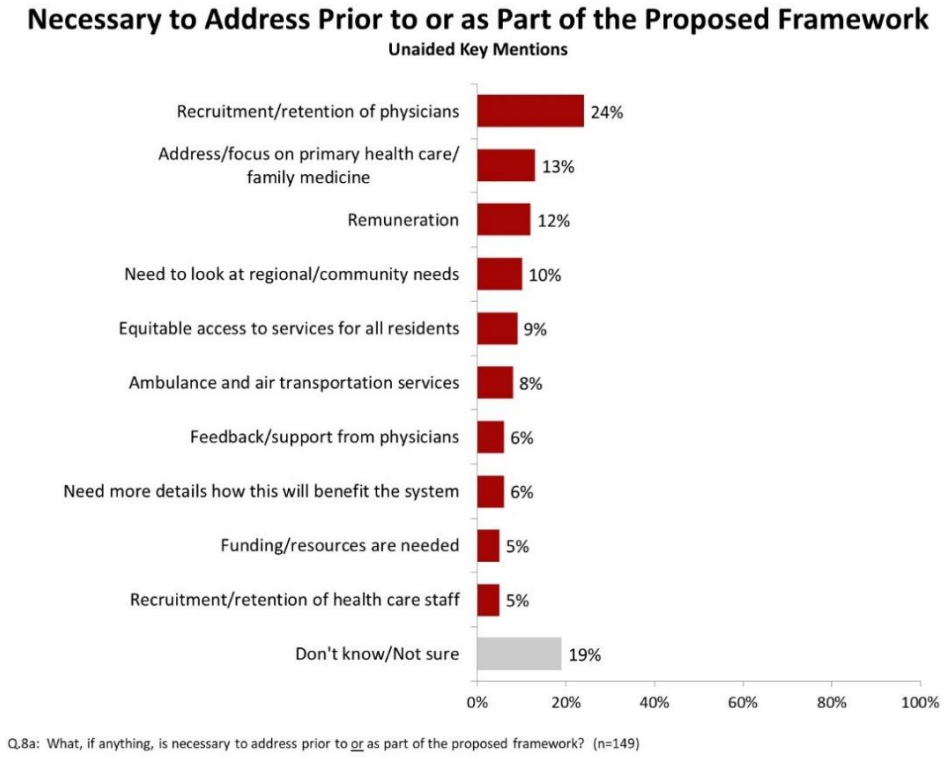
> "Current FFS is antiquated, disease and not prevention based, and not patient/family/community centered. This needs to change to help with recruitment and retention (for family medicine at least)."

Further with respect to **recruitment**, many physicians commented on the **inability to retain our medical school graduates**. While they noted that this needs to be addressed in part by addressing issues that make practicing in the province unattractive, some did comment on the need for a commitment from students trained in the province to practice in the province for a certain amount of time. In that regard, it was observed that in some countries there is a service commitment of all medical school graduates to practice in a rural location for a minimum of one (1) year.

"We have to STOP subsidizing medical students who promptly leave our province! We have to place emphasis on attracting people interested in working in rural settings, insuring them that they will be supported both medically and socially. We have to put a greater emphasis on family medicine as a rewarding career. I would certainly raise tuition to unsubsidized levels unless the person is willing to work in the province. I would also go far as to offer perks to any physician who is willing to work in rural areas either generalist or specialist such as guaranteed paid CME and/or tax incentives…. There has to be a dedicated back up team of physicians for locum coverage both of family physicians and (as much as possible), specialists too…."

Others suggested that for the community teams to be successful, there will need to be a shift in **how family physicians are trained** to align with this team-based model of care. Family physician training programs will need to be redesigned to incorporate team-based care into their training. Further, many physicians practising in rural and remote areas are IMGs and are not versed in team-based care. They will require philosophy, cultural, system and process training in order to thrive in this proposed model of care.

Quantitative findings affirm the importance of a focus on recruitment and retention of physicians, with it being the most frequently identified element that needs to be addressed prior to or as part of the framework. Other elements relate to this include the need to address family medicine and to examine remuneration. Of note, family physicians were more apt to identify a focus on primary health care than specialists (24% vs. 3%), as well as remuneration (17% versus 6%).



Q.8a: What, if anything, is necessary to address prior to or as part of the proposed framework? (n=149)

Those interviewed anticipate that if this framework is implemented, there will be pushback from both the public and some physicians as most people do not like change. It was acknowledged that the **public needs to be educated** (perhaps through a PR campaign) on the changes, why they are occurring and the impact. Moreover, there needs to be a willingness to see the changes through and not be deterred by public opinion.

> "Good PR with communities to ensure their buy in to a reorganization, reinforcing that these changes are not a reduction in service, but a more logical approach to issues arising. The belief that everyone needs a CT, an MRI and a PET scan has to be addressed, re-educated and the risk of causing harm with unnecessary investigations discussed."

There was also a call for full **transparency of the decision-making process**. Going forward, it was recognized that it will be important that the decisions made regarding what services and supports will be provided at each of the sites be done so in a transparent manner. It was recommended that decisions be made based on a comprehensive review of best practices, standards of care, acceptable wait times, empirical data as well as cost-savings and that this process be free of political interference.

> "Remove big capital investment projects such as new hospitals, PET scanners, radiation treatment facilities from the plate of politicians and have a non-political group of "sages" make recommendations. The working group on the New Health Accord is a good example of such approach. I think we need to insist that this becomes the preferred way of making strategic decisions in health care in the future."

It was also agreed that **frontline health care providers need to be engaged in the decision making and implementation processes**. Their knowledge and expertise should be used to guide the decision-making process. Their endorsement and buy-in will be key to the framework's successful implementation.

Given the challenges with geography and weather noted throughout this report, many identified **virtual technology** as a critical component of this model. It is seen as playing an important role in ensuring timely access to specialist care throughout the province. With the aid of virtual technology, specialists will be able to assess and determine which patients need to be see in-person and/or require further diagnostic investigations. It is believed that such an approach will serve to facilitate the coordination of diagnostic tests and procedures, reduce patient travel and provide timelier access to care. That said, many physicians noted that virtual care should be considered a complement, not a replacement, to in-person, and care should be taken that virtual care is used appropriately. There are concerns that the inappropriate use of virtual care can lead to missed diagnoses and poorer quality care.

Having a **provincial health record/single instance of Meditech** was seen as important component to the success of this proposed model. Having access to the results of diagnostic tests, regardless of where they are performed, will serve to avoid duplication and lead to greater efficiencies. While this level of technology will require a significant upfront financial investment, it was felt it will be very beneficial long-term.

> "With patients travelling all over the province for treatment, it would make it so much easier for us physicians to provide better care because we'd be able to see all the data. Trying to juggle between Meditech and Healthe NL is a slow and tedious process."

Further to the **access to specialists'** care throughout the province, a variety of points were made including:

- There needs to be clear and systematic referral channels and contacts for specialists, with built in accountability to ensure rural and remote areas are serviced by specialists.
- While virtual care is viewed as a key component of ensuring access to specialist, it was also suggested that there be an expectation and commitment of specialists to visit rural and remote areas on regular schedules.

A **robust paramedical transportation system** is deemed to be a fundamental component of the new model. It was recognized there is a need for more paramedics, especially advanced care paramedics, who can treat conditions in the field in rural and remote areas, along with a more robust land and air ambulance infrastructure. Notwithstanding, there are still concerns about the functioning of this system in inclement weather, and when there is a requirement to travel a significant distance for care.

> "It is not financially feasible or necessary to have so many hospitals in our province with duplication of services in some areas. Regionalization and centralization makes sense. I do strongly feel a better transport system is vital to making this work in a safe and effective manner."

The need to **examine the current infrastructure** to ensure that the remaining sites have the physical capacity and necessary human resources to manage the additional demand that will be generated from the closure of services at other sites was also highlighted. In particular, it was noted that emergency departments (EDs) have to function efficiently for this model to work. Currently at times, 90% of the beds in the ED are filled with admitted patients and the ED is unable to function. There is skepticism given the critical situation in St. John's now and the lack of capacity that it will be feasible to redirect services to St. John's. There needs to be a clear plan for how services in St. John's and other centralized areas will handle the higher volume.

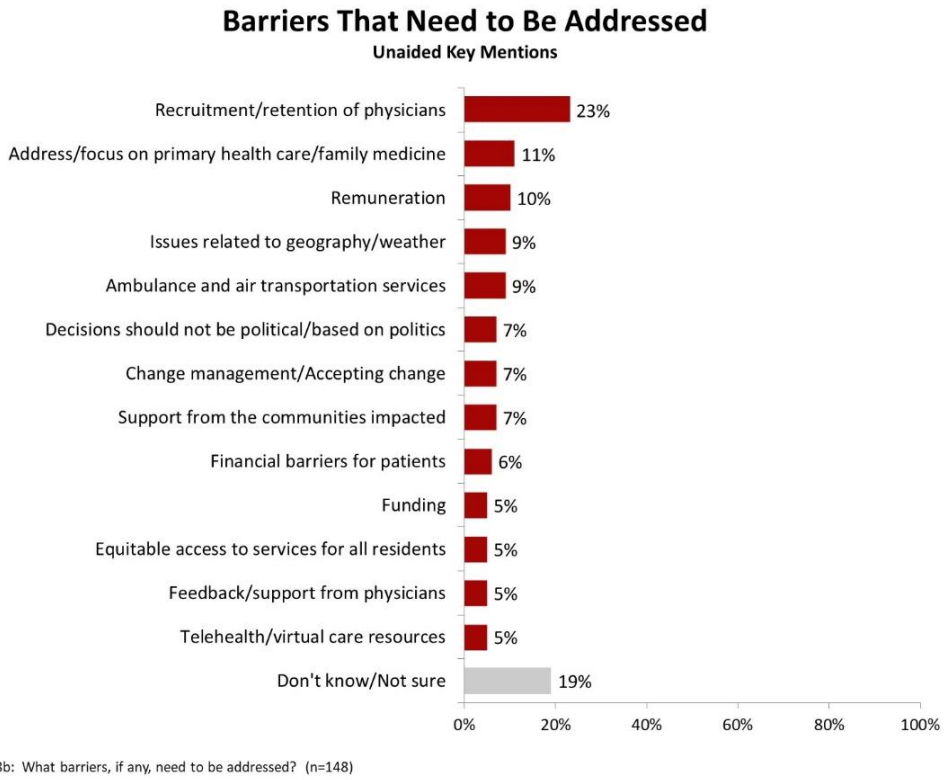
> "Resources in tertiary care and regional hospitals MUST increase to deal with increased patient volume."

Communication and clear guidelines regarding transfer protocols was also identified as an important success factor. There needs to be clear guidelines on transfer protocols – what stays at the local site versus what gets transferred. It was recommended that there needs to be a provincial operational

mechanism that includes a physician who can make decisions based on on-site assessments regarding where the patient should be transported, regardless of catchment area. In other words, determination of where to transfer patients, needs to be based on what the patient needs, not the closest hospital.

Physicians also pointed out support for efficiency and innovation can contribute to the success of a revamped health care system. It was agreed that various programs and processes should be reviewed to ensure efficiency and quality outcomes.

Physicians were asked via the survey what barriers need to be addressed, with the results paralleling the success factors.

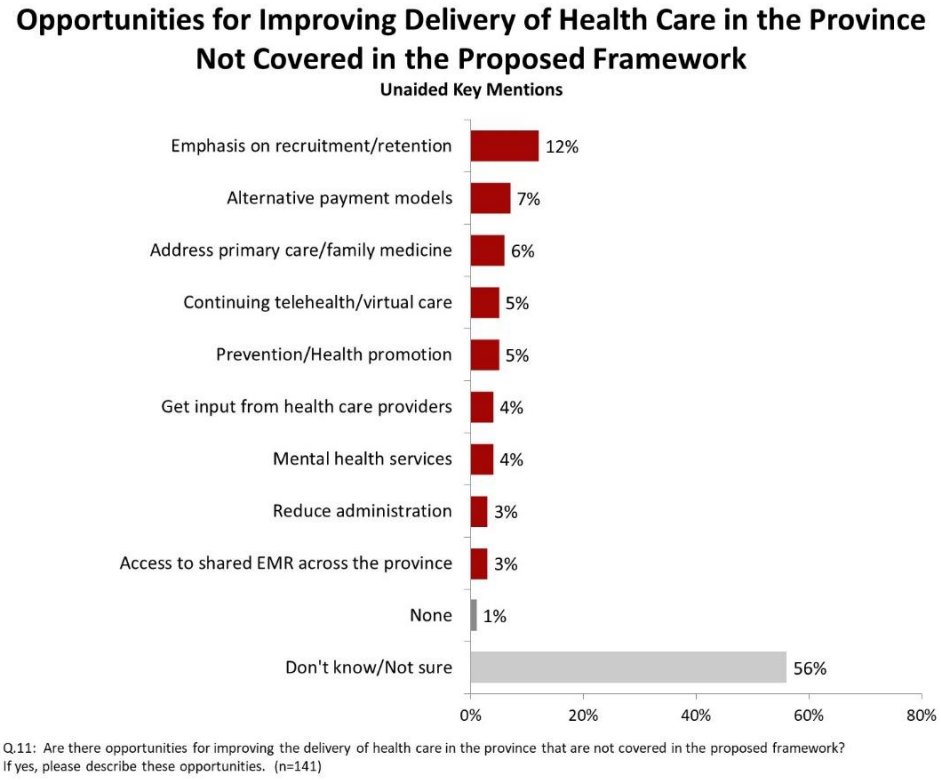


Q.8b: What barriers, if any, need to be addressed? (n=148)

Of note, other barriers to a team-based approach were noted including referral processes and organizational and workplace structures are not always conducive to flexible care. Indeed, it was noted that team-based care, and other improvements, would have evolved more naturally if the environment was conducive to doing so. In sum, the current structure has not facilitated the natural evolution of team-based community care, and it is important that these barriers be addressed as part of the system redesign.

4.5 Areas Not Addressed by the Framework

Physicians responding to the survey were asked what opportunities for improving the delivery of health care in the province were not covered in the proposed framework. More than one-half did not provide a response, and the opportunities that were identified were each mentioned by a small percentage. Most prevalent was an **emphasis on recruitment and retention**. This echoed a common thread throughout the research with a concern about where the health professionals required by this model would come from. Other mentions also reflect sentiments expressed throughout the consultations.



Likewise, key informant interviews/written submissions also often identified a **lack of attention afforded to recruitment and retention.** Other aspects noted as not being taken into account in the proposed framework included:

- **Pharmacare.** Several aspects with respect to pharmacare were noted, one being the limited access to support by certain segments, i.e., those working, but with a lower income – 'the working poor.' As well, it was noted the program makes decisions on the basis of cost, not necessarily appropriateness of prescription. This means doctors spend time advocating for coverage that is usually denied. A framework needs to take into account pharmacare and specifically how to ensure patients get appropriate, affordable access to pharmacare.
- **Evaluation and data collection.** The framework does not outline how the proposed changes will be monitored to see if they are having the intended impact. By way of example, it was

observed that the ending of the trauma registry means critical information is missing from service and quality analyses.

- Work environment and quality of life. Physicians and other health care providers often have work/life balance challenges. COVID-19 has compounded many stressors as health care providers have been under significant pressure and have been required to work long hours during the pandemic. They are burnt out and are unable to focus on the big picture in this current state. There is a need to acknowledge this state within the context of the framework and focus on creating a positive and supportive work environment, that extends well beyond the current pandemic. There is clearly a sentiment among physicians that the current working environment is not conducive to a sense of well-being and this has been the case long before the pandemic.
- Patient centred care. It was felt that the model being proposed is a system care model as opposed to patient centric model and does not address how we meet the needs of patients in a patient centric way.
- Social determinants of health. The social determinants of health are considered foundational to the solution, but are absent within the context of this system re-design.
- Mental health, addictions, chronic disease and homecare. It is unclear how these areas will be addressed under this proposed framework.
- Referral process. Some questioned how the framework address the reality of red tape arising from the existing referral process.