NEWFOUNDLAND AND LABRADOR
MEDICAL ASSOCIATION

June 23, 2020

Honorable John Haggie
Minister, Department of Health & Community Services
Government of Newfoundland and Labrador
P.O. Box 8700
St. John's, NL
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Dear Dr. Haggie,

I am responding to your letter of June 19, 2020, particularly regarding the termination of the FFS Physician Work Disruption Policy for COVID-19 Pandemic Event (PWDP) on July 6, 2020. I look forward to discussing these issues when we meet on June 24th.

The way this decision was made is troubling to the NLMA. It shows a continued lack of regard for partnership, timely planning and fair-minded communication. The decision leaves many unanswered questions and problems that should have been discussed and resolved prior to informing physicians of the result. It reinforces several years of declining relationship between government and the NLMA. A weak relationship hinders innovation and creates missed opportunities. The NLMA and the government need to find a new path in our relationship, which is a topic for another day. The topic for today is to create solutions for the new problems that will emerge by July 6th.

Our members have overwhelmingly told us that they wish to return to normal levels of patient care as quickly as possible. This motivation lies behind the "Your Voice" consultation report on re-opening health services that we sent to you several weeks ago. Like many other service providers, FFS doctors are ready to accelerate the volume of patient services now. They want to work. Patients' health conditions are going undiagnosed and untreated. Many necessary surgeries and procedures are not occurring. This results in preventable suffering for patients and will lead to increased strain on the health care system. This is also contributing to a growing wait list and the backlog of cases will have to be triaged as many non-urgent cases may have now become urgent since the shutdown. Given the low prevalence for COVID-19 in our province, we believe the time has come to return to normal as rapidly as possible, and we trust that you agree.

The biggest problem with the termination of the PWDP is that many parts of the health system remain significantly below capacity and will likely remain there for many months. The NLMA has not been informed by government about planning targets for returning to normal levels of volume, so we have gathered information from members in various disciplines. (see data attached) The picture that emerges is that a significant number of medical services will be remain substantially below 80% of normal volume. RHAs control which services are allowed to

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re-start in RHA facilities, the allocation of resources, the rules for PPE, and the number of patients to be seen per clinic/service. The problem, therefore, is that the volume of patient care is held back from returning to normal levels due to the decisions made by others. As a consequence, your decision means that many doctors who, in the early stages of the pandemic agreed to be available for hazardous Covid-19 work, and who worked on a Covid unit or an assessment centre, are now being jettisoned from the PWDP before they are able to work near normal levels.

Our province seems to be much slower than other jurisdictions to re-open health services despite our lower disease prevalence (see attached data). Unless we do a better job getting services back to normal, waitlists will grow exponentially. There needs to be balance between the re-opening of the system and the reduction of the PWDP. Right now, the balance does not exist as is evidenced by the low level of medical services capacity that is being provided in this province.

There are two possible solutions for this problem. One is to instruct the health system to make all the changes necessary so that patients can receive at least 80% of normal patient service volume by July 6th. Bold action and concerted effort will be a victory for patients, and it will be fair to physicians who stepped up to provide pandemic services. However, if the health system cannot make the necessary accommodations to allow resumption of at least 80% of normal services by July 6th, then the PWDP should be reinstated for physician groups that are constrained from working at reasonable levels of volume for reasons out of their control.

If FFS physicians are not provided with greater consideration, it means they are being targeted by government. If a surgeon who normally performs 10 surgeries a day can only perform 5 per day for the foreseeable future, due to scheduling, PPE and other rules, that surgeon is the only health professional in the operating room who is penalized by the health system. How can this surgeon count on the health system doing everything in its power to get the volume of patients up to normal levels?

The foregoing problem description also applies to community-based patient services to varying degrees. There are several disciplines where virtual care is not an adequate substitute, and in-person care is constrained because the physicians rely on provincial guidance for PPE usage and physical distancing. These practices are therefore equally constrained by the health system rules in re-building their volume of patients. For physician groups where virtual care combined with in-person care can produce at least 80% of normal service levels, we agree there is no requirement for PWDP. Of course, this feature was already built into the program, as the 80% ceiling operated as an incentive to resume normal services as soon as possible. While we do not have data, we are certain many doctors were able to achieve close to or above 80% of normal patient volume despite being part of the PWDP.

A second major problem is the adequacy of the virtual care code. If the health system, including community-based clinics, remains significantly below normal capacity after July 6th, many

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physician groups will be more reliant than ever on virtual care. From the outset of the pandemic, many specialty groups found the single rate to be inadequate as a substitute for in-person consultations and follow-ups. The government responded by saying if physicians sign up for the PWDP they will get 80% of normal compensation, so inadequate virtual care codes are not a problem. As of July 6th the PWDP will be gone, so it is now a major problem. The work of hundreds of doctors will be immediately under-valued.

Thankfully, the solution for the virtual care problem is simple, and has already been put in place by many provinces (see attached list). The solution is to allow FFS doctors to use the MCP fee schedule for virtual visits. Some provinces have opened the whole fee schedule, and some have provided a set of codes that are relevant to most virtual care needs. We also need to resolve the problem of preceptor billing for the work of learners through virtual means. The NLMA asks for an immediate dialogue on these matters so that the solutions can be available in Newfoundland and Labrador starting on July 6th.

Other problems related to the termination decision are as follows:

1. What will happen in the case of outbreaks or a second wave of the virus, if accompanied by service closures and a surge in the need for doctors to participate in pandemic-related services? Will it reactivate the PWDP, turning it on and off as necessary?

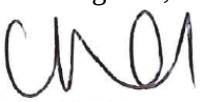
2. The manner in which new physicians exiting their residency can establish a practice with a reasonable income is now a greater puzzle. The NLMA had proposed using the PWDP for this purpose.

3. Many physicians have pandemic work assignments, such as in assessment centres, in July. With the program ending, are these work assignments also ending? This work was linked to participation in the PWDP which will no longer be in place.

4. With the removal of the PWDP, FFS doctors are no longer protected if their earnings are interrupted due to Covid-19 illness as a result of providing care to infected patients or a required 14-day isolation period following exposure to an infected patient or health care worker. Was this the government's intention? The lack of this protection in the context of outbreaks or a second wave is a key issue.

We are still receiving feedback from our members and we may have additional issues to add. We look forward to discussing these issues with you on June 24th.

Best regards,



Charlene Fitzgerald, MD, CCFP, FCFP
President

Estimate of Current Volumes of Medical services, by Discipline,		
Specialty	**Estimated current service volume/capacity**	**Commentary**
Family Medicine	25% - 75%	The limiting factors for full on in-person clinic: • Time to clean between patients • Lack of PPE To get to normal capacity in person, GPs would need to work almost twice as long which would also involve doubling staff hours – a cost that would be unbearable for family physicians. Virtual care must continue post-pandemic and include an expanded list of visit codes. Many patients are not doing well psychologically.
Anesthesia (St. John's adult)	20% - 60% (St. Clare's)	 Letter from HSC Anesthesia.pdf  St. Clares Anesthesia Info 201 St. Clare's: • 10 scheduled cases per day • 3:7 OR rooms utilized • PAC clinic 28% of volume • Chronic Pain is 25% volume with 4 pain procedures per week • Individual pain specialists seeing patients through virtual care; however, procedures/appointments are at 50% • Waterford ECT is at 50%
Allergy Medicine	50%	
ENT	20% - 30%	 Letter to Dept from ENT.pdf
GI	50% outpatient clinics 50% outpatient Endoscopy May increase to 60% by July 6, 2020	Colon screening is at 100% in St. John's; however, clinics are only held 0.5-1.0 days per month. The limiting factors are social distancing and PPE. Upper scopes require COVID testing prior to scoping making the addition of a COVID swab logistically

		challenging. Some patients don't show for swab and by default miss the scope.
Nephrology	20% - 25% Traveling clinics still canceled	
Plastic Surgery	25% consults/visits 30% minor procedures 10% -15% major surgical requiring GA	Virtual care provided to emergent patients amounting to approximately 20% of the normal volume of visits.
OBS/Gyn	50% - 60% clinic volume	Labor and Delivery as well as prenatal care volumes remain the same. Non L/D varies throughout the province, but overall, volumes are down.
Urology	20% - 25% (Central) Post COVID, system allows for 50% of pre-COVID capacity (Eastern)	May reach approximately 50% in Central Health but limited by OR access and COVID precautions. Throughput may be less with summer slowdown schedule. The backlog is not decreasing.
General Internal Medicine	50% outpatient clinics	Decrease in scheduled outpatients attributed to RHA.
General Surgery	30%	Overall rate of work is 30% of normal workload in all areas – endoscopy, OR, minor procedures and clinics.
Dermatology	40% - 50%	St. John's specialist – '*With the current Pandemic situation, social distancing, and sanitizing rooms between patients, abiding by the government guidelines, here is my situation:* • *I have lost 2 of my 4 nursing staff; one decided that the risk of pandemic is too great for her as she has severe Asthma, and unable to wear a mask all day at work; one nurse is off with 3 young kids. I have 2 nurses at present, with 1 nurse on the phone and computer all day long, attempting to move patients in our upcoming months of schedule.* • *Many patients in March/April/May and early June were refusing to be seen face to face for skin surveys, impossible to do virtually - and these patients will be calling in July to be rescheduled. There is nowhere to put them in my schedule, so I am putting patients into my lunch hour.* • *Last year during this week I saw 234 patients, with half of them new consults; this week I have 130 follow ups, no new consults (this is my schedule for the next 6 months)*
Cardiology	45%	May reach 50% - 60% by July 6, 2020
Orthopedic Surgery	25% - 30% OR case volume (EH) 10% workflow capacity (WH) 50% clinic time seeing 35% of patients (EH)	Social distancing/PPE requirements limiting

Neurosurgery	30%	May reach 50% by July 6; most services will be emergency procedures. Very few elective cases being completed. Intense competition among surgical specialties for elective OR time. Clinics limited to 12 patients per 3-hour clinic compared with 17 – 20.
Radiology		HCS/RHAs deciding what work is getting done, not Radiologists. (WH) EH – *'As of June 25 when the province goes to level 2, we will be at approximately 60% of normal capacity in the radiology department. Due to the limitations in place with social distancing we are limited in our capacity to expand our services any further.* *In July the department will have very little if any capacity to expand services, the capacity will likely be reduced. The unions have negotiated 2 weeks' vacation for all employees so we will be unable to maintain the current service levels with the reduced staffing.'*
Respirology	10% - 30% clinics 30% - 50% procedures	With current restriction from EH, specialty will be at 40% - 60% in July
Ophthalmology	45% - 50% average (some as low as 10%)	Very little information from EH. Barriers to reaching normal volumes include: o No cataract surgery other than emergency; o No plan to start elective surgery; o No access to diagnostic testing other than urgent; o Reduced number of patients/clinics due to social distancing; Will be difficult to reach 65% - 70% of normal volumes unless there are significant changes with regard to availability of regular OR time and access to hospital-based testing.

Interprovincial Scan of Re-open Capacity

Newfoundland and Labrador

- **May 13, 2020** – RHAs announce the gradual resumption of some health-care services including medical imaging, endoscopy, cardiac diagnostic, and surgical services. Physicians to review patient lists to identify high priority cases.
- **June 10, 2020** – Some additional health-care services resumed in the Provincial Alert Level 3, including appointments in ambulatory clinics including physician clinics, allied health services such as (but not limited to) rehabilitation services, physiotherapy, and audiology, along with appointments in community health, and women's health services such as (but not limited to) fertility services. Services that were previously increased in Level 4 - medical imaging, endoscopy, cardiac diagnostics, laboratory services, and surgical services - will continue to increase in Level 3. Providing care virtually will continue to be the first line of service delivery for most care providers. Where virtual visits are not appropriate, in-person services will incorporate physical distancing and the use of personal protective equipment (PPE).

Ontario

- **April 27, 2020 -** the Government of Ontario releases A Framework for Reopening the Province.

    - Hospitals are expected to reserve at least 10% of acute care capacity, subject to any alternate regional capacity (i.e., at least 10% surge capacity of inpatient medical, surgical, and critical care beds available within 48 hours).

Saskatchewan

- **Phase 4 – June 22: Full Resumption of Services**
    - All remaining services and procedures to resume 'normal' operations, including elective surgeries and previously postponed surgeries
    - Re-open hip/knee outpatient clinic

Manitoba

- **Restoring Services: Phase 3**
    - **June** 21 **- Therapeutic or Health Care Businesses:** Occupancy limits lifted for all health professions. Service providers must continue to implement measures to ensure that members of the public are reasonably able to maintain a separation of at least two metres from others, except for brief exchanges.

PEI

- **PHASE 4 - June 26: Health care**
    - All non-urgent health care services permitted

Quebec

- **In June**, Montreal hospitals were ordered by the Quebec Health Ministry to ramp up their elective surgeries.

BC

May 7 2020, A Commitment to Surgical Renewal in B.C. (https://www2.gov.bc.ca/assets/gov/health/conducting-health-research/surgical-renewal-plan.pdf)
https://news.gov.bc.ca/releases/2020HLTH0026-000830
"We expect to complete all lost surgeries within 17–24 months and renewal efforts will be ongoing well into the future."
"Target Timeline

- May 18: Surgical services begin, increasing capacity over four weeks to near normal pre-COVID levels;
- May 31: All private contracted facilities working at maximum available capacity;
- June 15: All existing operating rooms running at full available capacity;
- June 15 – October 15: Incrementally bringing on additional capacity through: | extending daily hours of operation; | adding Saturdays and Sundays to the schedule; and, | opening new operating rooms where available.

New Brunswick

June 11, Patients travelling for N.B. medical care don't have to self isolate, including N.S. top doctor (https://www.cbc.ca/news/canada/new-brunswick/robert-strang-self-isolation-medical-care-new-brunswick-border-1.5608489)
Geldart [vice-president clinical of Horizon Health Network] … said over the last week, hospitals completed 98 per cent of their regular surgical volume.
May 12, Hospital services restarting for 'urgent, critical' elective surgery Horizon patients (https://www.cbc.ca/news/canada/new-brunswick/health-services-horizon-vitalite-covid-19-elective-cancer-surgery-1.5566609)
"Dr. France Desrosiers, Vitalite's vice-president of medical services, said… if all goes well, the yellow phase coming in two to four weeks will allow them to increase to 70 per cent."

Nova Scotia

June 15 – "At the Cape Breton Regional Hospital, surgical throughput over the last four weeks is at 70 per cent of the previous capacity." "All aspects of diagnostic imaging have achieved 75 per cent of previous capacity and staff are working to increase that."
https://www.thetelegram.com/news/canada/surgeries-other-hospital-services-in-cape-breton-ramping-up-as-covid-19-units-empty-out-462322/

Northwest Territories

May 20, Elective surgeries expected to resume at full capacity by June (https://nnsl.com/yellowknifer/elective-surgeries-expected-to-resume-at-full-capacity-by-june/)
"Lisa Giovanetto, communications officer with the Northwest Territories Health and Social Services Authority, stated in an email last week that the release of the GNWT's Emerging Wisely document has allowed the department to focus on increasing capacity to hold elective surgeries at full capacity for June 1.

"The plan is to gradually ramp up elective surgery capacity in order to reach close to full capacity by June 2020, however this could change at any time depending on the pandemic situation," she stated.

COVID-19 E-Scan on Virtual Care and Income Stabilization
June 17, 2020

Jurisdiction	Virtual Care
Nova Scotia	• All office based non-procedural services that are normally provided in a face to face setting will be permitted to be reported whether they are provided in person, by telephone, via telehealth network or via a PHIA compliant platform. • Services include – limited visits, consultations, psychotherapy, and counselling.
PEI	The following services are billable when delivered by telephone: • Limited office visit • Health Promotion Counselling • Psychotherapy • Diagnostic and Therapeutic Interview • Expanded to include Consultations
New Brunswick	• Most of the Fee Schedule for visits (100% rates of in-person) expanded until August 28th • Virtual care – $45 single code for all, plus psychiatry codes, potentially opening further pediatric, neurology and FP codes, consultations codes can be billed at existing rates – codes are being paid • Working on continuing expanding to multiple fees • Virtual care will continue post-pandemic
Quebec FMs	• Telephone or video visits paid at the same in-person fees for office visits. • Virtual care improving same day access
Quebec SPs	• Telephone and video visits paid at the same rate as in-person • No longer a cap. Can now bill 24/ 7
Ontario	• 4 codes minor, intermediate, advanced, specialist (unit-based codes, rounded to nearest $5)
Manitoba	• 2 virtual care tariffs, office visits and psychotherapy • All disciplines can bill using fee code 8321 (paid equal to the regional history and exam rate or the relevant subsequent visit rate for the specialty). • April 27 agreement-in-principle to expand virtual visits to cover the following areas, which will better support both specialists and family physicians in their work. o Virtual psychotherapy by family physicians and non-psychiatric specialists, as an alternative to in-person tariff 8580. o Virtual psychiatric care by psychiatrists, as an alternative to in-person tariff 8584. o Virtual chronic care visits for PCH and long-term care home residents, as an alternative to in-person tariff 8511.

	○ Other Tariffs for specialized areas include child development assessments and chronic pain management were shared directly with affected physicians.
Saskatchewan	• Pandemic Telephone code in place for all physicians. • Interest from SMA and Government to expand codes for FPs (consultation, counselling and chronic/complex care) to keep virtual care going permanently. • Possibly expanding virtual care for FPs (consultations, chronic care and counselling), age premiums and afterhours premiums do not apply to virtual care codes. • Specialist code implemented as of May 4th. • Announced expanded virtual care codes for specialist consultations/visits and psychotherapy/psychiatry services (one-size fits all pricing, all time-based codes); can be billed by psychiatrists and others entitled to bill (including eligible GPs).
Alberta	1. Visit Services – HSCs: 03.03CV and 03.03FV 2. Consultation Services – HSCs: 03.08CV and 08.19CX 3. Mental Health Services – HSCs: 08.19CV and 08.19CW No daily cap. Rates linked to fee schedule.
British Columbia	• Consultations, office visits, and non-procedural interventions where there is no telehealth fee may be claimed under the face-to-face fee with a claim note record that the service was provided via video technology or telephone are payable by MSP. • Virtual care fees set at in-person fee rates