NEWFOUNDLAND AND LABRADOR
MEDICAL ASSOCIATION

COVID-19: Physician Advice on Restarting Health System Services

May 15, 2020

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Introduction

During these unprecedented times, health system decisions are being made rapidly in response to our changing circumstances and new information about COVID-19. It is imperative that decisions of government and RHAs on reactivating the health care system include input from physicians.

This report compiles and synthesizes input collected between May 5 and May 13, 2020 from more than 200 practicing physicians and medical residents in Newfoundland and Labrador on COVID-19 and is provided to support decision-making by the Department of Health and Community Services and the four regional health authorities (RHAs). It captures medical advice on how health services should re-start, how virtual care should be sustained, and how public health measures should operate during the remainder of the pandemic. While this report does not necessarily reflect the NLMA position on these topics, the NLMA may supplement this overview report with other specific reports as we complete more detailed assessments of the input.

Physicians are proud to support the provincial response to COVID-19 and are committed to providing patients with access to timely care in a manner that ensures the safety of patients, providers and the population.

Demographics

- 214 physicians participated in the consultation with approximately equal representation from family medicine and other specialties.

- 117 respondents are in St. John's, with the others spread across Newfoundland and Labrador. All RHAs are represented.

- 70% of respondents are fee-for-service (FFS), 20% salaried and a small number of physicians are paid through alternate funding arrangements (e.g. an APP).

Key considerations for decision-makers

1. Prioritizing patients whose care has been delayed, or have progressed from non-urgent to urgent, will require a whole system approach. Developing a process to rank and identify these patients will be essential in ensuring timely care. Clearly defining and streamlining processes between community physicians and RHAs will be the most effective way to reduce the pressures on the health care system.

2. Safety for patients, physicians and other health care workers is a top priority. Personal protective equipment (PPE) for community physicians is an urgent need; community physicians can help divert volume away from emergency rooms, acute and long-term care settings, but only if they can safely provide services to patients.

3. Continuation of virtual care in the short-term and post-pandemic is essential.
    - Virtual care can be appropriately used to limit the number of patients requiring in-person care, which is invaluable when the provincial PPE supply is limited and future supply is uncertain.
    - There is a need to refine the one-size-fits-all approach to the pandemic virtual care assessment code by applying virtual care to specific in-person fee codes in the MCP Schedule.
    - Virtual care alone is not a solution to NL's doctor shortage, but it has the potential to improve patient access and improve physician recruitment and retention. When appointments can be conducted virtually, physicians can reduce wait times and potentially increase capacity to take on more patients.

4. The Physician Work Disruption Policy (PWDP) for FFS physicians is anticipated to be needed throughout the pandemic. Physicians do not see their practices returning to pre-pandemic levels in the coming months. The PWDP could be a bridge to a blended capitation model for family physicians.

5. Mental health and wellness of health care workers must be considered and supported during reopening of normal health care services.

The hospital system: pressure points and priority setting

Pressure points

Physicians gave detailed feedback on the pressure points that deserve top priority in the earliest stage of restarting RHA services. Delayed interventions and cancer care were mentioned by the majority of respondents. While there are common priorities, physicians noted that planning must consider local context:

> *"Pressure points will be different, depending on the facility, and whether the patient population is rural vs. urban."*

Elective surgeries

Delayed elective surgeries are an area of significant concern and there is a real sense of urgency around delivering this care. Some conditions will become urgent/emergent while the patient is waiting. Complication rates can be expected to increase as wait times grow. Physicians report that these patients are driving emergency room usage and can require pain management with narcotics while they continue to wait.

> *"Delayed interventions will be the biggest thing to deal with first, as many patients' conditions may have changed since they were first referred."*
>
> *"Urgent elective surgery needs to go first. We are seeing these patients in Emergency and holding them with narcotics. Not good."*

At the same time, caution is needed to safeguard the province's physician supply:

> *"Being a solo practicing specialist, if we start elective work, in case of exposure to coronavirus and quarantine - It may be difficult to get locum cover. Most of the locums come from out of province and they themselves need fourteen days quarantine."*

Cancer care

Cancer care was identified as a key pressure point, with an urgent need for services across the spectrum of care from screening and investigations, to consultations, surgery and management. Endoscopic procedures were specifically named by several physicians as being a priority in relation to cancer care.

> *"Also agree anything regarding possible cancer diagnosis with symptoms needs to be priority - especially endoscopy (concerning symptoms not being scoped right now)."*
>
> *"Cancer ORs have been delayed. Most cancer is not treated for intent to cure without surgery. We have been trying to do some but are still backed up. These patients should be top priority."*

Laboratory services

Fifteen physicians agreed that the biggest issue they face is a need for increased laboratory services. Specific services named include: A1C, labs for medications, renal functions, thyroid profile, CPK, liver function, and wound swab and urine culture when they are essential to determine dosage adjustment for certain medications and to choose the right antibiotic.

> *"The current wait is too long at 10 days. Or at least make emergent slots available daily."*
>
> *"We absolutely need more lab access to properly manage chronic diseases such as diabetes."*

Laboratory capacity was identified as an issue. Physicians identified that when making decisions about expansion of services and extending OR times, laboratory resources must be considered. A large influx of cancer cases would, for example, drive complexity and turnaround time.

Diagnostic imaging

Diagnostic imaging was a common response. It may be possible to hold off on some diagnostic imaging, but there are priority areas that should be considered. Sixteen physicians agreed that first trimester ultrasound for dating and fetus count is standard of care and cannot be considered elective even during the pandemic. Important CT interval follow-up was also identified as a service that should be considered for restarting. Cancelled diagnostic imaging will need to be triaged and loss to follow-up minimized.

Prenatal care

Respondents flagged prenatal care as a priority. First trimester ultrasound was identified as essential, see 'Diagnostic imaging' above. Several physicians agreed that delays in determining pregnancy risk level must be avoided to enable management of high-risk pregnancies, and one respondent noted the urgency of pregnancy-related complications.

Endoscopic procedures

Endoscopic procedures (colonoscopy, EGD, etc.) were named by many physicians as a key service that should reopen.

Cardiopulmonary testing

Many physicians named cardiopulmonary tests like EKGs, Holters, exercise stress tests, pacemaker checks, cardiac catheterization and outpatient cardiac angiogram as priority services. One physician noted that they currently must send a patient to the ER if they need an EKG. Another respondent gave the following feedback on three procedures done in hospital EKG departments that could now safely proceed:

> *"Exercise Stress Tests: I think these could now begin for patients with ischemic-like chest pain which is increasing in duration, intensity or frequency. Many usual requests for EST are probably reflexive and can be safely postponed.*
>
> *Pacemaker Checks: These should also be done for patients whose pacemakers are close to replacement; pacemaker longevity of 12 to 18 months based on their last check-up, especially pacemaker-dependent people. Other routine annual checks can be safely postponed.*
>
> *Holters: Patients with syncope compatible with an arrhythmic cause should have their Holter monitoring soon. Other indications such as palpitations without other symptoms can be postponed."*

Other areas

Other areas noted by respondents that should be considered include:

- Screening and preventative care like childhood vaccinations, cervical screening and mammography. These may not feel urgent compared to other areas, but they are important and there are consequences for delaying them.
- Some urological interventions like cystoscopies and TURP for obstructive uropathies that are not responding to conservative measures.
- Women with uncontrolled uterine bleeding, pelvic mass causing pelvic pain or suspicious of pelvic cancer, or HSIL (severe cervical dysplasia).
- Reactivation of regular Urine Drug Screening (UDS) and limited carry doses for addictions care.

Criteria and processes for priority setting

There is broad recognition of the complexities and challenges of determining how to assign priority to services and patients. Respondents gave the following feedback on priority setting:

- Priority setting must happen in both acute settings and community settings to triage patients. This will be different from the way that some physicians have typically practiced; for example, offering walk-in hours for patients does not fit with a triage approach.
- Referrals to specialists, diagnostic imaging and testing will all need to be reassessed to determine the level of urgency. To help accomplish this quickly and minimize loss to follow-up, trained patient navigators could contact patients to obtain current information on their condition. Family physicians have a role here, but will not have capacity to do all the patient contact, triage and resending of referrals.
- Approaches may differ from health authority to health authority; for example, what works in Eastern Health may not be the best strategy in another RHA.
- Criteria for priority setting could include:
    - Services that affect overall mortality and/or quality of life, a key area being cancer care
    - Testing to decide on treatment for serious conditions
    - Patients with a faster progression of disease
    - Length of time waiting for a service
- Shared decision-making on which patients get priority could be done by panels of physicians (specialists and the family physician) or by a tribunal with physicians and broader representation including ethics, allied health professions and administration. Centralized approaches may be more efficient, but need to be balanced with the responsibility of an individual physician to care for their patient. Current decision-making structures can be leveraged to address needs:

> *"Current tumour boards and triage panels exist and could develop systems to address who gets what best next step or triaging surgeries/biopsies."*

- Processes must be clear to all physicians, and to administrative staff in RHA facilities and private clinics, to ensure accurate information is given to patients and to family physicians making referrals.

> *"For new referrals to specialists and radiologists, it will be challenging to prioritize the urgency as the patient's situation may have changed. Sending the referrals back to the family physician may not be the answer, as assessing urgency will need to be balanced with other duties, and there could be further delay. We could advocate for a trained navigator (perhaps an allied health care professional) that could call the patients to assess their status and refer back to the family physician if the condition has changed."*

Safety

Respondents gave feedback about safety for patients, physicians and other health care workers across all the themes of the consultation.

Personal Protective Equipment

PPE concerns are pervasive. Availability of PPE is described as the number one factor that will limit the province's ability to restart health care services, particularly in the community where it is identified as a barrier to patient access.

- Community physicians need access to the same level of PPE protection as RHA workers to provide safe care to patients.

> "I feel safer working in the respiratory assessment clinic than I feel in my own family practice! We need access to the same level of PPE protection as RHA facilities."

- PPE kits for community physicians are inadequate to properly protect patients and physicians in community offices, and discussion and guidance are needed to address this issue. Physicians report the RHA-provided PPE kits will allow one physician in a clinic to see a maximum of five patients, which could be easily used up in a day. They also report that they are not able to reorder these PPE kits.
- Community physicians cannot source their own PPE and need access to the RHA supply. A lack of availability of PPE for community physicians will limit their ability to see patients in the community and have a direct effect on the pressure felt in hospitals and ERs.

> *"PPE is a huge concern. Private clinics cannot order PPE and have very little left. It will be difficult to resume normal clinic without"*
>
> *"It is critical that physicians who are capable of providing care for patients in their own areas are able to do so and provided with appropriate PPE. The emergency department is already seeing an increase in volume and it is impossible to social distance patients appropriately in our environment. I am worried that despite our best efforts, patients who are immunocompromised may be forced into a crowded waiting room or have to wait in a hallway on a stretcher as we need more private rooms to care for possible COVID-19 patients."*

- Community physicians report that if they are successful in purchasing any PPE they are subject to unreasonable price gouging. This is exacerbating the financial situation for FFS physicians who are already experiencing a decrease in income during the pandemic and continued overhead costs.
- Physicians are looking for practical public health guidelines and best practices for the use of PPE in non-RHA settings to ensure it is used in the most effective and efficient way to protect patients and physicians, while also managing available supply.
- Providing care safely takes more time, from phone screening patients and spacing appointments, to donning and doffing PPE. One physician reported that changing in and out of PPE takes up to 30-60 minutes of their day. Most community physicians do not have support staff to disinfect clinic rooms between patients and this is another draw on their time. All of these factors reduce the time available for patient care.

Testing

Testing was a source of some discussion, with several respondents noting that broad availability of testing for health care workers and patients entering acute care facilities would help with safety and managing PPE use.

Mental health

Respondents spoke frankly about mental health and work-life balance. Access to resources to support mental health and well-being will continue to be important going forward. Uncertainty and fear about how physicians will take care of their patients, how patients will receive essential services, and how the health care system will proceed going forward were identified as sources of mental fatigue. Transparency and communication from government and RHAs can help ease these concerns.

> *"As for mental health, I am more stressed about delaying my patients' treatments knowing that surgeries will become more complex what could have been done under local may now require a general anesthetic – some will have a longer recovery and may have a less favourable outcome."*

Another respondent wrote about the new, different way they are practicing during the pandemic:

> *"Part of protecting our mental health is recognizing and adapting to our inefficiencies. It takes longer to do just about everything right now (PPE, clothing changes, separating patient appointments, phone screening patients, booking lab appointments, calling for every diagnostic image required). We interact less with our colleagues, but time needs to be dedicated to this in our new work days (to keep up shared care, collegiality, and high standards of patient care as well as work satisfaction)."*

Respondents report that the challenges they experienced pre-pandemic with securing locums have now escalated. Now, any out-of-province locum would have to quarantine for at least 14 days before they can go to work. This is flagged as an area of particular concern and source of fatigue for rural physicians and solo-practicing specialists. Keeping the workforce physically and mentally healthy over the extended pandemic period will be important, and this may require measures to relieve this pressure. More overtime for already exhausted health care providers could expose the system to further weakness.

Hospital supports and ancillary services

Respondents discussed the importance of PPE and testing in the hospital setting, as well as support for diagnostic imaging, endoscopy procedures, and labs to address backlogs. They also identified other areas that would support the pandemic response, including:

- Distancing policies and a mechanism to monitor and maintain them to ensure adequate physical distancing in waiting rooms and lounge areas.
- Review of environmental cleaning and air exchanges in hospitals, with increased support for housekeeping to do enhanced cleaning.
- Restrictions on hospital visitation and the number of persons who can accompany a patient for procedures should be gradually and carefully eased and remain more restricted than pre-pandemic.
- Flexible approaches to scheduling. For example, split shifts in the lab and diagnostic imaging could allow for distancing. Some work could be shifted to evenings and weekends instead of focusing on weekdays from 9-5.

- Extended hours for some services to help clear the backlog, with consideration of, and support for, understaffed services like pathology.
- Consider moving faster on some less complicated needs; this could mean starting elective procedures that have low rates of post-op admission and complication due to capacity before more urgent procedures with very high complication rates.
- Investment in telehealth for improvements and efficiency.
- Use virtual care to shift patients away from the ER: triage patients, provide after-hours care, etc.
- Explore whether smaller regional centres with ORs have capacity to help clear backlogs for simple procedures.

Retaining flexibility in the health care system

Virtual care

The new Pandemic Virtual Care Assessment Code has allowed a significant expansion of non-face to face medical services in the province. Respondents identify the continuation of virtual care as being essential to retain flexibility in the health care system in the coming months. Community-based physicians report that they do not have adequate PPE to see patients in person and that while the PPE shortage persists, virtual care must remain in place to ensure continuity of care for patients. Virtual care is a valuable tool during the pandemic because it supports social distancing measures by limiting the number of patients presenting at clinics.

> *"In the short term (for many months) I would expect that the majority of our visits will have to continue by virtual care as we gradually increase in-person visits. As many of us work in large group practice facilities, shared waiting rooms will limit the volume of in-person visits possible while maintaining physical distancing. We continue to have very minimal PPE available."*
>
> *"Virtual care has been a real lifesaver during this extraordinary time. I've been able to have my clinics via telehealth (and some on phone) and can't imagine what it would be like if I hadn't been able to do this. I was doing some telehealth before and this has shown me how incredibly valuable this is. I will definitely be keeping this as an important part of my practice."*

Respondents provided suggestions on how to improve the pandemic virtual care assessment code beyond the pandemic:

- The majority of physicians supported continuing to restrict the location of the provider to ensure NL doctors treat NL patients. It was suggested that the virtual care code might be further restricted to ensure patients are accessing their own physician through virtual care whenever possible to promote continuity of care. These restrictions were described as important to prevent private virtual care providers, whether out of province or in province, from cherry-picking NL patients and providing one-off, episodic care.
- Another suggestion to improve the virtual care code is to enable preceptors to bill code 50000 for learner encounters, to appropriately remunerate FFS physicians for the care resident learners are providing virtually. Teaching and supporting residents for virtual care visits should mirror what happens in clinic.
- Respondents recommended that there not be any difference in payment for phone and video visits. Many patients prefer telephone calls, including seniors and patients without access to reliable internet.
- The flat rate for all types of visits, for all types of physicians, was identified as an area for improvement. If the code is to continue, there is a sense that a more precise tool is needed to appropriately compensate physicians that reflects the fee codes for in-person visits.

> *"[In family medicine…] a flat rate for all visits discourages the comprehensive care of complex patients. So, there need to be premiums for complexity or a shift away from FFS altogether. The VC flat codes encourage episodic care, not continuity of care. BUT Virtual care is great, don't want to remove it from my day. Just needs tweaking."*
>
> *"As a specialist, I envision continuing to see as many follow-up appointments as possible virtually, but that is not a viable option for new consultations, and those will be the ones to be seen in person. Having said that, the fee for a virtual visit is less than a follow-up visit, so if virtual care is preferred and to be encouraged to reduce patients coming to clinic, the fees should be adjusted to be more equal."*

One respondent described improvements to the telehealth system that would maximize its potential:

> *"Appropriate fees need to be put in place for all potential users. At the moment, booking clinics using the system can be cumbersome. About 25% of the time, families can't sign on due to technical reasons and this is quite frustrating for them. Internet connections are often not great in some areas in NL. I agree that e-prescribing would be a huge benefit, as would the ability to order investigations electronically. (I am not able to do either at the moment with EH.)"*

Role of community-based physicians

Moving services from hospital to community settings

Several respondents suggested that moving services (e.g. minor procedures, local anesthetic procedures) out of hospital settings to community settings be considered to support social distancing and reduce the backlog of canceled procedures. The community setting could be a non-hospital RHA clinic or a FFS physician office. If this was to take place, consideration would need to be given to compensating FFS physicians for overhead costs to mitigate the associated financial burden.

Similarly, it was suggested that primary care providers could help offset some of the urgent needs of long-term care and personal care homes through virtual care to decrease ER visits for these vulnerable populations.

Physicians working on pandemic response

Community-based physicians have been pulled by RHAs to work in multiple areas in the system to support pandemic response. As their clinics become busier again, a plan is needed to ease physicians away from those areas and back into their offices.

Physician services in community offices

Community physician offices were not ordered to close during the pandemic emergency, but the social distancing guidance of the Chief Medical Officer of Health, and the encouragement of virtual care, dramatically reduced the amount of in-person patient care and office opening days. Specialists and family physicians have both raised the importance of two interconnected pieces: continuing virtual care and continuing income protection for FFS physicians.

Continued pandemic work disruption policy

Respondents gave feedback that the continuation of income protection for FFS physicians is needed because in-person care will be slower, less efficient and more expensive in the short-term as physicians ensure that care is delivered in a way that is safe for themselves, patients, and staff.

Respondents suggested continuing the Pandemic Work Disruption Policy, and several suggested that now is the time to consider alternative payment models like blended capitation.

> *"We need to be able to continue to look after our patients as best we can (in-clinic or virtually at our own discretion), without having to worry between maintaining patient safety, and maintaining earnings adequate enough to keep our practices running."*
>
> *"If we are to remain in FFS models of care, long term income stabilization will be necessary to acknowledge the decreased efficiency, higher cost and lower volume involved in clinical practice. This seems like the time to consider other payment models."*

Continued MCP support for virtual care

Respondents see virtual care as essential while social distancing measures and PPE are required. Community offices are not built to accommodate social distancing and staggering visits (e.g. creating a longer workday) to space patients out isn't financially feasible on a large-scale and will need to be limited to patients who require an in-person visit. One physician noted that continuation of the virtual care code will reduce pressure on FFS physicians to crowd their waiting rooms and see high numbers of patients to raise their income back to a normal level to meet overhead demands.

Public health measures

Respondents offered the following feedback on public health measures to control another outbreak when normal health services and the economy begin to reopen:

- NL's geographic isolation and rurality is a strength and continued monitoring of incoming travel is our best defence.
- There must be a sustainable process for testing all potential cases and rapid and intensive contact tracing. Contact tracing through an app may be more effective if numbers of cases rise.
- Test all incoming travelers to the province (by boat or air) and new arrivals to remote communities. We have learned that recommending self-isolation does not always work. Tests should also be done for all suspected COVID-19 cases and for workers at health care facilities.
- Consider repeat testing for symptomatic patients given the test's sensitivity level and the rate of false negatives. Also consider a different approach to testing that combines antigen and antibody tests to increase the test's sensitivity.
- There is a need for a streamlined process to verify whether patients presenting at an ED with COVID-19 symptoms have been previously tested by public health. This will become an issue as restrictions lift, allergy season starts, and during the fall flu season.
- Implementation of social distancing has had success. Consider extending lockdowns in isolated, rural areas with few ICU beds and limited access to health care services.
- Continuation of public health measures like wearing face masks in public places and hand washing to prevent transmission.
- Stronger acknowledgment of pre-symptomatic and asymptomatic spread.