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Options for Advancing a Permanent Virtual Care Compensation Framework in Nova Scotia

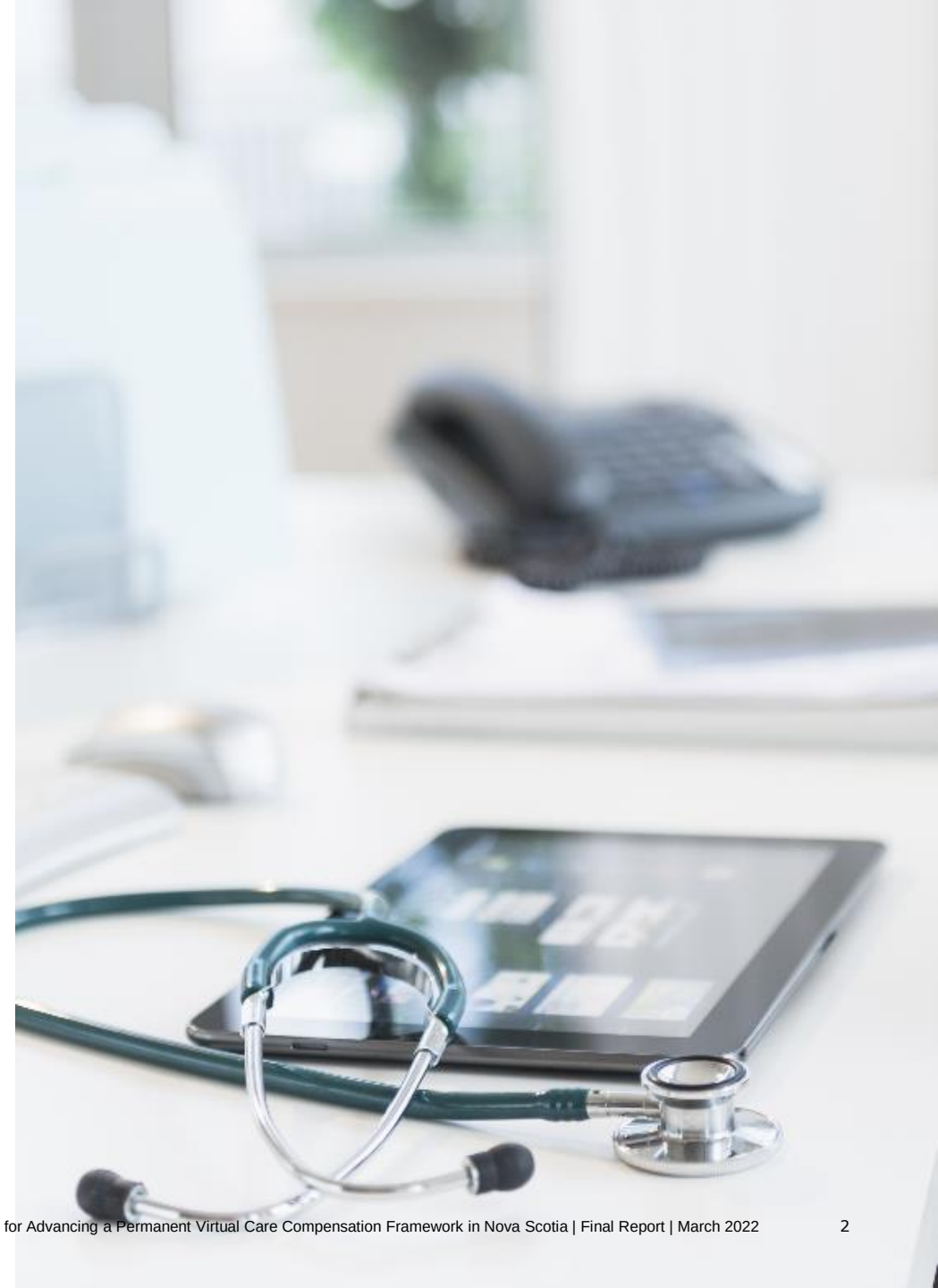
Final Report | March 10, 2022

Preface

This report serves as one of many inputs the Government of Nova Scotia will consider as it relates to the future of virtual care across the province.

The intent of this work was to provide the Department of Health and Doctors Nova Scotia with recommendations for a more permanent approach to compensating synchronous virtual care, as well as compensation options for asynchronous virtual care modalities (i.e., secure patient messaging and e-consults).

It should be noted that all recommendations presented in this report may require additional financial and policy analysis prior to implementation as part of the overall budget for Physician Services.



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Introduction

In September 2021, the Department of Health & Wellness (DHW) released a ministerial mandate to "complete a full consultation within our first three months in government, in conjunction with Doctors Nova Scotia (DNS), to determine what specialties and health providers can expand the scope of their practice to telemedicine, ensuring proper billing codes."

DNS and DHW engaged Deloitte to support the consultation process and provide options for a more permanent approach to fee codes for synchronous and asynchronous virtual care (secure patient messaging), as well as e-consults.

The options for a more permanent approach to the use of virtual care had a specific focus on:

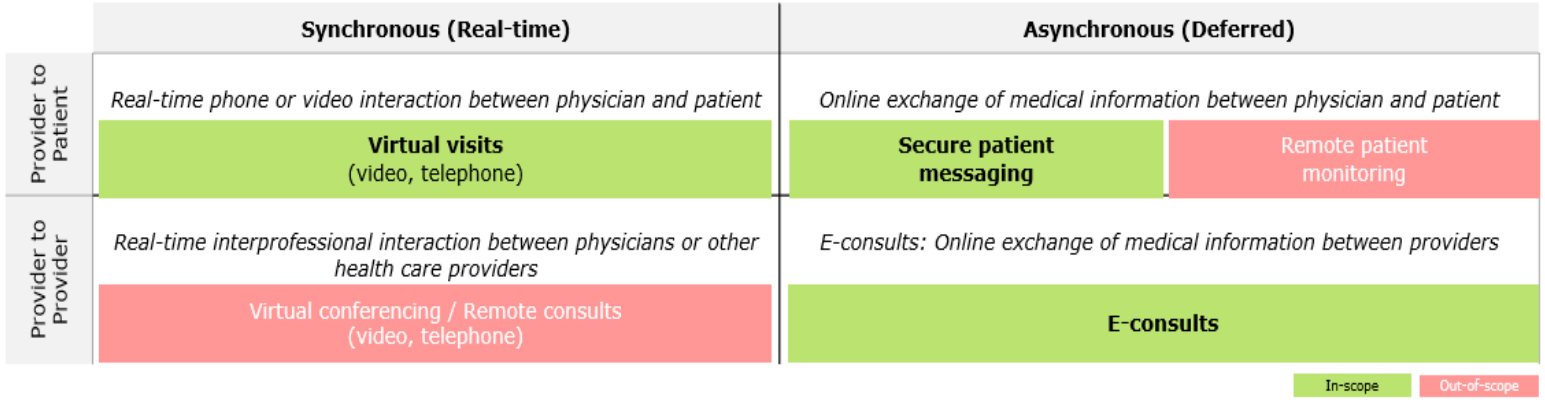
- Understanding leading compensation practices for synchronous provider-to-patient consults, and determining whether evidence supports deviating from the current practice of payment parity between in-person and virtual visit fee codes; and
- Identifying and evaluating compensation models for asynchronous secure patient messaging, and e-consults between providers.

This work is one of many inputs (i.e., research, projects, etc.) Government will consider as it relates to the future of virtual care across the province.

Project Scope

Building upon previous work undertaken by Deloitte for the Atlantic Provincial & Territorial Medical Associations (PTMAs), Deloitte:

- Engaged the membership of DNS to understand perspectives on the application of virtual care in clinical practice and preferences on compensation;
- Engaged stakeholders across the wider health system to better understand the role virtual care can play in achieving key strategic priorities in Nova Scotia;
- Refreshed the analysis of leading Canadian and international jurisdictions to explore and catalogue the main compensation models within a fee-for-service framework and to identify best practices through interviews and desktop research; and
- Developed a final report including recommendations and conclusions for each in-scope virtual care modality as shown in the graphic below.



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Summary of Quantitative and Qualitative Data Collection

- A major impetus for this project was engaging with the Nova Scotia physician community, as well as other key health system stakeholders, to gain insights on a long-term approach to compensating physicians for synchronous virtual visits, as well as feedback on compensation models for the two in-scope asynchronous virtual care modalities.
- Through this work over 400 unique Nova Scotia physicians were consulted through various means (i.e., online survey, webinar, focus groups), and additional consultation was undertaken with key Nova Scotia health system stakeholders, select PTMAs and government representatives from across the country, as well as individuals from Deloitte's global network of subject matter advisors. This engagement was further augmented by desktop research to catalogue the latest policy statements, whitepapers, and other publicly available literature across virtual care modalities. At a high level, Deloitte's findings include the following:
  - Direct consultations with DNS e-Health Committee members and Section Chair leads as part of focus group sessions revealed the benefits of all virtual care modalities are well understood.
  - Approximately 60 physicians attended a virtual care compensation webinar and were provided the opportunity to learn about and opine on the benefits and challenges with select compensation options, as well as key policy decisions, across in-scope virtual care modalities.
  - An online survey completed by 329 physicians revealed that 75% believe synchronous virtual care should continue to be compensated on-par with in-person visits; over 90% believe physicians should be compensated for both providing secure messaging with their patients, and/or requesting and completing e-consults, with mixed feedback on the preferred compensation approach.
  - Nova Scotia health system stakeholders were aligned that both synchronous and asynchronous virtual care are important service delivery options for meeting the needs of progressively more complex patient populations, and have the ability to generate new capacity and improve access within our health system; however, there were also concerns that we have let virtual care move too quickly and therefore, all long-term compensation decisions must be carefully assessed.
  - Through our discussions with other Canadian jurisdictions we learned others are considering the same key policy issues as Nova Scotia (i.e., payment parity, volume/service capping, guidelines around clinical appropriateness, etc.). There is a strong desire to learn from one another, and replicate what has worked or is working in other jurisdictions.
  - Deloitte's network of global subject matter advisors provided perspectives from other international jurisdictions, including the United States, the United Kingdom, and Australia.
  - Finally, our rapid scan of the latest research suggests that, particularly from a synchronous virtual care perspective, it is far too early to make policy decisions grounded in robust data. More time is needed to collect evidence around virtual visits as the world moves to our new post-pandemic normal.

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Recommendations

- A key component of this project was developing a set of guiding principles (see box at right) to guide the analysis of options and recommendations for a permanent approach to virtual care compensation. The development of these guiding principles leveraged Deloitte's research into leading practices, as well as our broader experience developing funding models in other jurisdictions, and reflects government's long-term vision for healthcare in the province.
- The recommendations below focus specifically on compensation for each in-scope virtual care modality, and assume that all enabling requirements are in place to encourage broad adoption of each modality (e.g., technology infrastructure, change management, training, etc.). It should be noted that there are key dependencies/issues not explicitly described through our recommendations that will warrant additional dialogue between physicians and government to ensure the ability to successfully encourage broad virtual care adoption (e.g., technology governance structures, funding, etc.).

Synchronous Virtual Visits

1. Government should continue to allow for synchronous virtual visits to be billed on-par with in-person visits over an extended temporary time horizon (i.e., a minimum of two years or until a sufficient evidentiary base has formed) to provide physicians certainty in their practice planning, and to allow for the use and impacts of virtual care to be assessed prior to making a decision around permanency of fee structures.
    - While there are reasonable, yet contradictory, arguments to deviate from payment parity there is a limited evidentiary base that points to decisive rationale to deviate from today's status quo.
    - It is too soon to make evidence informed decisions, and a permanent decision should be deferred until the evidence can be further collected and the impact of the payment parity policies are better understood.
2. During this time, Government should ensure the appropriate data collection mechanisms are in place to allow for robust system-wide data collection on the utilization of telephone/video visits across specialty areas as part of their total case mix, and the impact on overhead expenses.
    - Such data collection mechanisms should include:
        - The creation of temporary virtual care fee codes and/or stricter enforcement of text modifiers on existing face-to-face codes to prevent under reporting of virtual care utilization and services across specialties.
        - Conducting analysis to measure the impact on clinically appropriate virtual care adoption on physician overhead expenses.
        - Ongoing patient and provider feedback.

Guiding Principles:

The Steering Committee identified the following principles to guide a long-term approach to virtual care compensation:

- **Strategic Alignment:** A permanent compensation structure should support expansion of appropriate use of virtual care.
- **Modality Neutrality:** No particular modality of care should be unduly profitable in comparison with others.
- **Low Administrative Burden:** Expanding virtual care should not increase administrative burden.
- **Value for Money:** Physician compensation for virtual care should be tied to the value of the interaction to the patient, provider, and wider health system.
- **Cost Certainty:** A permanent virtual care compensation structure should have a reasonable level of predictability that gives the payer the ability to forecast costs with a reasonable degree of confidence.
- **Feasibility:** Implementation of payment options must cover the majority of clinical use scenarios and be considered achievable from a technical, political, and financial standpoint.

Executive Summary

Recommendations (cont'd)

Synchronous Virtual Visits (cont'd)

3. Once sufficient evidence has been gathered, Government should reevaluate payment parity between face-to-face and virtual visits, and between video and telephone virtual visits to determine permanent payment structure(s) and fee codes.
    - The relative clinical value of different exchanges across specialty areas should be assessed, as well as materially significant differences in health system costs that would warrant differential rates to be established.
4. Government and DNS should work together to ensure the appropriate monitoring and accountability mechanisms are in place to complement the existing policies on the provision of virtual care.
    - Monitoring mechanisms should leverage data analytics for peer group reporting (e.g., within specialties, care settings, geographies, etc.) and to identify significant outlier patterns of physician virtual care utilization, while also identifying leading practices. Outliers that may be deemed to negatively impact on patient care, may then be subject to practice audits or subsequently referred to existing mechanisms for holding physicians accountable for sound professional judgment.
    - All volume caps/restrictions introduced during the pandemic on the provision of virtual care, in relation to in-person care, should be phased out once monitoring mechanisms are in place.
    - While the relative mix of in-person to virtual services may vary greatly by specialty, policies should ensure patients have the ability to access services in-person (other than 811 triage or emergency departments), if required and/or desired within a reasonable timeframe.
5. To address the confusion with virtual walk-in services in the health system today, Government and DNS should work together towards a solution for virtual walk-ins that will meet the needs of patients and providers.
    - The inconsistency in how virtual walk-in services are offered across the province (i.e., VirtualCareNS pilot for unattached patients vs. traditional walk-in clinics' inability to offer virtual services) has frustrated providers and patients alike. Any approach to compensating virtual walk-in services should carefully consider supporting continuity of care in primary health.

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Recommendations (cont'd)

Asynchronous – Secure Patient Messaging

1. Government should re-establish a stipend-based model to compensate physicians for asynchronous secure messaging with their patients.
   - The stipend-based model should include the ability for a tiering of fees to allow for physicians to be compensated at multiple thresholds based on factors such as caseload complexity, number of patients utilizing the service, or patient message volumes.
   - Physicians value simplicity. Ensuring there is limited additional administrative burden placed upon them is critical when selecting a preferred compensation approach. Stipend-based models are positively recognized for this characteristic by physicians, and were also identified as a highly feasible option with significant cost certainty when assessed against virtual care compensation guiding principles.
   - A stipend-based approach to secure patient messaging will encourage adoption by physicians and patients, and will help prevent overuse - a concern that is common with fee-for-service approaches. Of note, asynchronous secure messaging with patients is focused on non-emergent care.
2. To inform the development of the stipend, DHW and DNS should work together to advise on anticipated service utilization and required service volumes, as well as other critical enablers to support broad physician adoption.
   - In addition to ensuring a straightforward compensation model is in place, physicians will require broader support in other areas to ensure successful implementation of the modality in their practice (e.g., technology platforms, change management, training, support managing patient expectations, etc.).
   - Additional detailed design (e.g., financial analysis, business case development, etc.) will be required to ensure stipend development is appropriately aligned with the overall budget for Physician Services and the fiscal priorities of the Government.

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Recommendations (cont'd)

Asynchronous – E-Consults

1. Government and DNS should work together to introduce a flat fee compensation model with unique fee codes to compensate both the requesting and consulting physicians for completing e-consults.
   - It is widely recognized that both the requesting and consulting provider should be compensated for the exchange. Like secure patient messaging, simplicity was valued above all for physicians. When assessed against guiding principles, flat fee compensation models for e-consults provide a highly feasible, simplistic approach that serves as a natural extension of the existing synchronous remote consult fees. The current rate for synchronous provider-to-provider consults (i.e., Health Services Codes 03.09L and 03.09K) provides a clear starting point for developing asynchronous codes for e-consults.
   - For requesting physicians, e-consults should adopt a flat fee model, per e-consult.
   - For consulting physicians, e-consults should adopt a flat fee model with time-based conditions (i.e., services can only be billed when e-consults have been responded to within a given timeframe).
   - Primary care physicians should be eligible to be the consulting physician when the requesting party is a non-physician health care provider (e.g., a duty nurse providing care to a resident in long-term care), or when the consulting physician has an identified functional specialty area within family practice (e.g., geriatrics, opioid treatment, etc.).
   - Additional detailed design (e.g., financial analysis, business case development, etc.) will be required to ensure fee development is appropriately aligned with the overall budget for Physician Services and the fiscal priorities of the Government.
2. Government and DNS should evaluate the implementation of asynchronous e-consult fee codes within a reasonable time horizon to understand the overall service utilization, as well as the impact on referral volumes and wait times for specialist services to determine whether adjustments need to be made.
3. Government should consider providing clarity on the nomenclature of the modality (e.g., e-advice) within the physician manual to avoid confusion with other synchronous and asynchronous virtual care modalities.

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Concluding Remarks

- The analyses and recommendations laid out in this report set out a clear vision and path forward to ensure Nova Scotia physicians are appropriately compensated for the virtual care they provide in a predominantly fee-for-service environment. This vision seeks to align all virtual care compensation decisions with broader health system strategic objectives, and to ensure compensation models are modality neutral, limit the administrative burden placed upon physicians, promote high-value care, provide a level of cost certainty to government, and are technically, politically, and financially feasible to implement and maintain.
- The majority of provinces across the country have been grappling with the same decisions being faced in Nova Scotia as it relates to synchronous virtual care. By taking a clear position on the inability to make long-term decisions in the absence of clear evidence or rationale, the province will be seen as playing a leadership role nationally in this space. Further to this, as one of the only provinces not currently compensating physicians for provider to patient and provider to provider asynchronous care, the potential for positive impacts to patient access, amongst other factors, bodes well for the future of our health system.
- As one of many inputs supporting Government's consultation around the future of virtual care, the implementation of these recommendations will not be easy, and will take time, but will be necessary to build a sustainable future for virtual care in Nova Scotia.

Introduction

Project Background and Objectives

Introduction

Transforming the health system and listening to and respecting all Nova Scotians are two pillars underlying the efforts of the new Government of Nova Scotia. These two pillars are reflected in the Minister of Health and Wellness's mandate letter. One of the responsibilities of the Minister is to expand telehealth/virtual care in recognition of the potential for improved patient access and provider productivity.

The Minister's mandate letter clearly states that any effort to expand telehealth/virtual care is to include broad consultation in partnership with Doctors Nova Scotia (DNS). Furthermore, the mandate letter also stipulates that the Department of Health and Wellness (DHW) must advance its planning for expanding the use of telehealth and virtual care in the first three months of the new government's mandate.

Building on previous work undertaken by Deloitte for the Atlantic Provincial & Territorial Medical Associations (PTMAs), DNS and DHW engaged Deloitte to provide options for a more permanent approach to fee codes for synchronous and asynchronous virtual care, as well as e-consults.

The options and recommendations for expanding the use of virtual care had a specific focus on:

- Understanding and applying leading compensation practices for synchronous provider-to-patient virtual visits and determining whether evidence supports deviating from the current practice of payment parity between in-person and virtual visits; and,
- Identifying and evaluating compensation models for asynchronous secure patient messaging and e-consults between providers within the context of wider health system change in Nova Scotia and the priorities of the government.

This report outlines Deloitte's key findings and observations from stakeholder engagement and jurisdictional research/literature reviews, along with final recommendations for each in-scope virtual care modality.

Objectives

- Engage the membership of DNS to understand perspectives on the application of virtual care in clinical practice and preferences on compensation.
- Engage stakeholders across the wider health system to better understand the role virtual care will play in addressing key strategic challenges in Nova Scotia.
- Refresh the analysis of leading Canadian and international jurisdictions to explore and catalogue the main compensation models within a fee-for-service framework and to identify best practices through interviews and desktop research; and
- Develop a final report including recommendations and conclusions for each in-scope virtual care modality.

Health System Context

The COVID-19 pandemic significantly accelerated the rate of virtual care adoption in Nova Scotia and it will continue to be an important tool for reshaping the health system to meet the needs of the population.

Expanding the use of telehealth and virtual care is a key priority of the Government of Nova Scotia in and of itself. The COVID-19 pandemic has helped providers, patients, and policy makers better understand the benefits of virtual care in enhancing access to health services and improving patient and provider experiences.

There are, however, several other key health system priorities that expanded use of virtual care helps supports, many of which will require a permanent approach to physician compensation.

Improve Access to Primary Health

Providing unattached patients with immediate access to primary health through virtual services and general expansion of scope of practice to support virtual modalities.

Address Surgical Wait Times

Supporting the attainment of surgical wait time benchmark standards by using virtual care, e-consults in particular, to improve access to specialist services.

Chronic Illness & Disease Management

Supporting the introduction of a new Chronic Illness Treatment and Prevention program that includes virtual care to support in-home treatment models for patients living with chronic diseases.

Helping Seniors Age in Place

Providing virtual services that help to keep seniors healthy, living and aging in place in their own homes, or in residential care.

Provider Recruitment and Retention

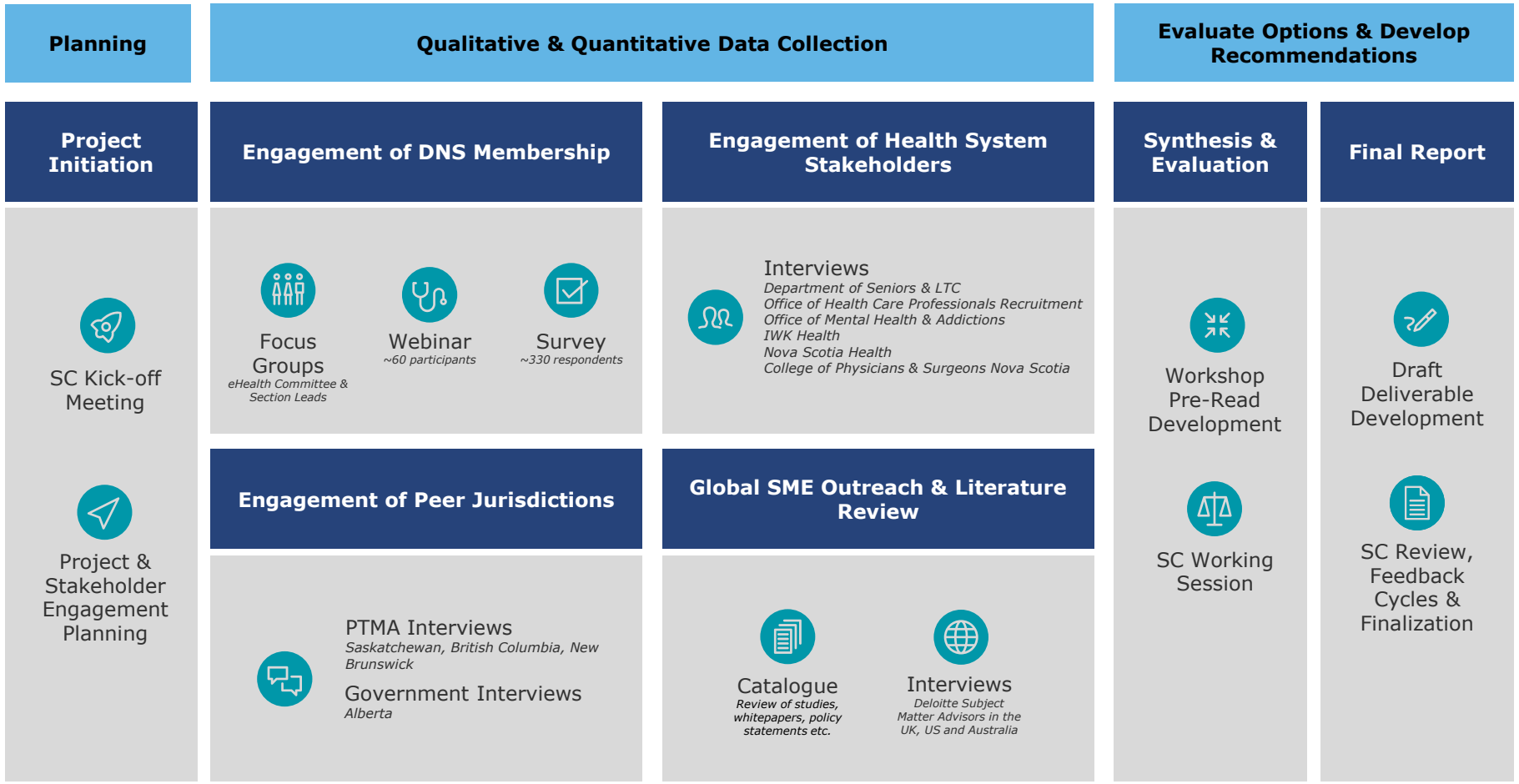
Leveraging a progressive virtual care ecosystem as a vehicle for attracting and retaining physicians.

Approach

The analysis of policy options and formulation of recommendations for virtual care compensation was informed by wide array of information sources. This analysis was overseen by a Steering Committee (SC) comprised of representatives from DNS and DHW.

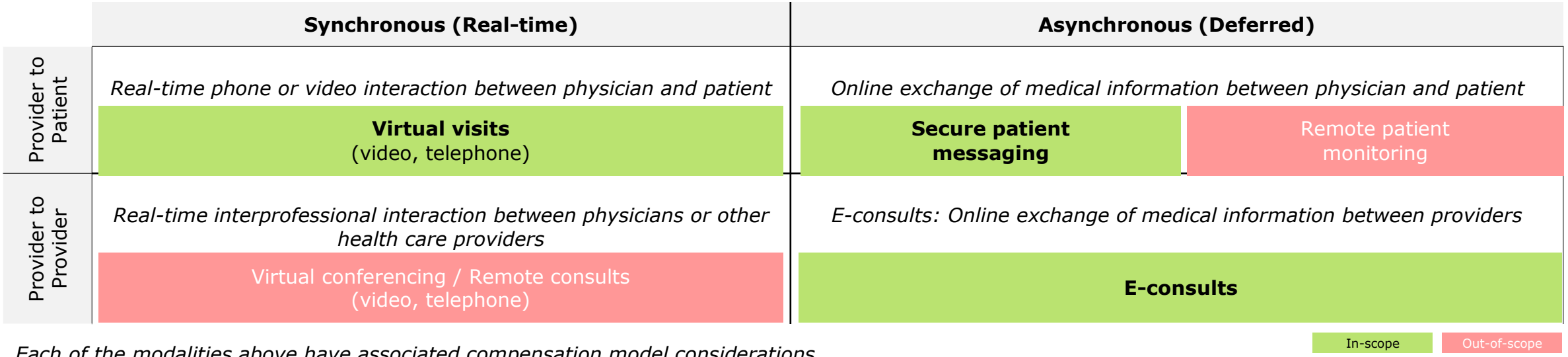
Engagement of physicians is a central aspect to DHW's approach to policy development for virtual care compensation. As such, significant time and energy was devoted to engaging the membership of DNS by providing multiple diverse options for providing input into the project. It was also important to frame virtual care compensation options and recommendations within the wider health system context, this was achieved by consulting with a myriad of stakeholder organizations.

As previously mentioned, this work built upon a prior jurisdictional scan and literature review performed by Deloitte for the Atlantic PTMAs. This work was refreshed by follow-up discussions with Nova Scotia's peer jurisdictions and capturing global insights that have emerged since the completion of the work with the Atlantic PTMAs.



Scope

The project was specifically focused on a subset of virtual care modalities and addressing specific policy questions for a permanent compensation structure.



Each of the modalities above have associated compensation model considerations

The options for a more permanent approach to the use of virtual care will have a specific focus on:

- Understanding leading compensation practices for synchronous provider-to-patient consults; determining whether evidence supports deviating from the current practice of payment parity between in-person and virtual visit fee codes.
- Identifying and evaluating compensation models for asynchronous virtual care and E-consults between providers.

Guiding Principles

The following six principles were developed with input from the SC to frame the analysis of options and recommendations for a permanent approach to virtual care compensation.

Strategic Alignment

A permanent compensation structure should support expansion of appropriate use of virtual care.

Expansion of virtual care should support improved access to primary care, reduced wait-times to specialty services, and the development of the health sector workforce.

Modality Neutrality

No particular modality of care should be unduly profitable in comparison with others.

A permanent virtual care structure should not undermine utilization of the most clinically appropriate care modality.

Low Administrative Burden

Expanding virtual care should not increase administrative burden.

Compensation models should allow physicians to concentrate on clinical services to maximize scope and ultimately optimize value to patients and the health system.

Value for Money

Physician compensation for virtual care should be tied to the value of the interaction to the patient, provider, and wider health system.

A permanent compensation structure should incentivize the appropriate use of health care resources.

Cost Certainty

A permanent virtual care compensation structure should have a reasonable level of predictability that gives the payer the ability to forecast costs with a reasonable degree of confidence.

Feasibility

Implementation of payment options must cover the majority of clinical use scenarios and be considered achievable from a technical, political, and financial standpoint.

The guiding principles represent DNS's and DHW's shared aspirations for a permanent structure for virtual care compensation in Nova Scotia. Vary rarely are the policy considerations for physician compensation straightforward, and these guiding principles were a mechanism for testing options and recommendations against "what good looks like". The guiding principles were developed based on similar funding and compensation initiatives and an informed view of the priorities and needs of Nova Scotia Health system, as previously described.

Synchronous Provider to Patient (Virtual Visits)

Synchronous Virtual Visits | Nova Scotia Context

The COVID-19 pandemic spurred widespread adoption of virtual care in Nova Scotia through the removal of traditional barriers and the need for physicians to adapt their practices.

Today's context

- Since the mid-1990s, synchronous provider to patient consultations have been supported using the TELE modifier, when care was provided through the Nova Scotia Telehealth Network. The limited fee code structure was used by a range of subspecialities (at fixed locations) for specific services.
- Prior to the pandemic, Nova Scotia's fee codes for synchronous provider-to-patient care included a flat-fee family physician-to-patient code and a specialist follow-up code for telephone visits only. These codes are remunerated at lower levels than face-to-face visits (approximately 70%). Uptake for these non face-to-face codes were low due to the lower compensation and the added administration burden for use of these codes.
- The Province was quick to respond to the demands of the pandemic by introducing a generic fee code with a single rate for telephone and video visits for all physicians across disciplines. This was quickly revisited and a revised approach allowed physicians to claim for all non-procedural services that would normally be completed in-person when the service was provided virtually.
- Physicians were then able to bill what they normally would for an in-person visit, including premium fees, regardless of the selected modality (i.e., in-person, video, telephone), and were instructed to include a simple text modifier on the existing face-to-face code to denote the mode of delivery (i.e., "Pandemic telephone, "Pandemic telehealth", "Pandemic virtual care").
- The temporary changes introduced to the fee schedule have been extended several times, with the latest extension for the fee codes set to expire on March 31, 2022. In December 2020, the Department of Health and Wellness released a policy statement on the provision of publicly funded virtual health services. The policy stated virtual care should complement in-person, as such it is expected that the majority of services provided should be in-person. This policy statement has been poorly received by many physicians.
- Through the height of the pandemic (i.e., March – December 2020), approximately 18.5% of physician services were billed as virtual care, with the majority of synchronous virtual visits provided by telephone. However, data quality issues relating to free text-entry to denote mode of delivery on the existing fee codes in claim submissions were noted by government, and therefore, overall service volumes are believed to be significantly under-reported.
- As Nova Scotia is now looking ahead towards a permanent approach to virtual care compensation, key policies issues such as payment parity, volume/service capping, and guidelines around clinical appropriateness are top of mind for physicians and other system stakeholders alike.

Focus of section - The key policy questions we seek to address:

- Does evidence support deviating from the current practice of payment parity between in-person and virtual visits?
- Should telephone vs. video virtual visits be compensated differently?
- Should physicians be limited in the number or percentage of virtual visits they can provide?
- Finally, are there differences across specialties that may warrant differential compensation?

Synchronous Virtual Visits | Jurisdictional Scan

Most provinces and territories have introduced fee code changes during the COVID-19 pandemic to support the transition from face-to-face to virtual visits.

Insights from the Canadian Provinces

- As part of this work we engaged with select PTMAs and provincial departments from other provinces, building upon our discussions that informed the 2020 Atlantic PTMA work, with a specific focus on changes that have been introduced over the past year for synchronous virtual visits.
- Prior to the pandemic, compensation for virtual care was at varying stages of maturity across provinces. COVID-19 has had a significant impact on the way in which virtual care is being delivered across the country. In particular, the opening of fee schedules and virtual care billing guidelines approved during the pandemic were critical steps in further enabling the adoption of both synchronous and asynchronous virtual care across the country. Most provinces and territories introduced temporary fee code changes to support the transition from face-to-face to virtual visits. For the majority of provinces and territories this meant creating new virtual fee codes for phone and video visits; however, others, like Nova Scotia, extended existing face-to-face fee codes for virtual visits.
- The rapid shift in billing guidelines and fee schedules through the pandemic is seen by some to be a potential catalyst away from traditional fee-for-service (FFS) models and towards more capitated, population-based payment models. However, some provinces are more focused on ensuring in-person access is not impacted by the rise of virtual care and have begun to encourage or direct physicians to resume in-person appointments feeling that physicians are not accessible to patients in their offices. The reduction of in-person appointments is thought to be impacting services in other areas (e.g., crowded Emergency Departments) and we are beginning to learn about the potential negative impacts to patient care and outcomes.

Highlights of fee code changes introduced during COVID-19 to enable synchronous virtual visits

	AB	BC	MB	NB	NS	NT	NWT	ON	PEI	SK	QC	YT
New virtual fee codes for virtual visits	Codes made permanent June 2020	Temporary telephone codes end date TBD	Duration of virtual visit tariffs TBD	Extended until March 2022		N/A (salaried physicians)	Duration of temporary codes TBD	Extended until September 2022	Duration of temporary codes TBD	Pilot program at 90% of in-person until March 2022		Duration of temporary codes TBD
Extension of existing face-to-face codes		Pre-existing video codes			Extended until March 2022						Duration of extension codes TBD	

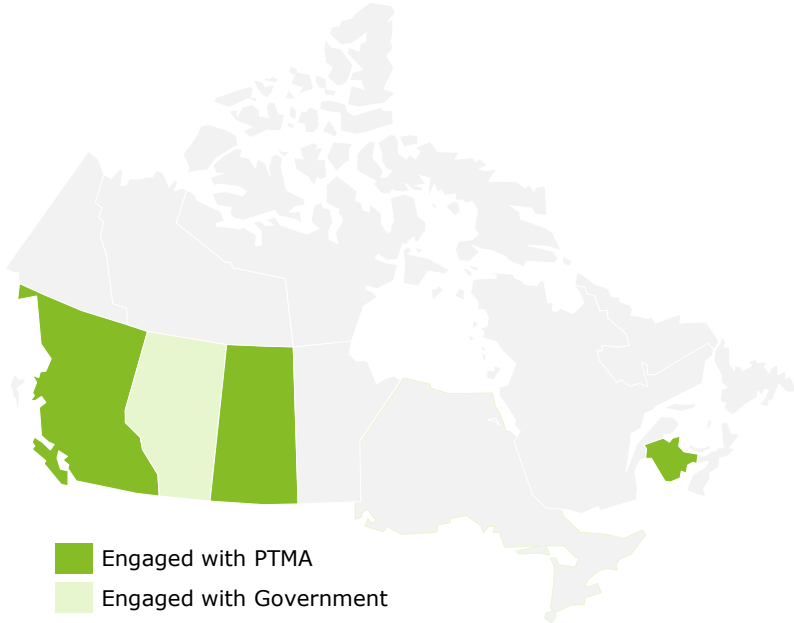
Synchronous Virtual Visits | Jurisdictional Scan (cont'd)

There is uncertainty across jurisdictions about what synchronous virtual care compensation policies will look like after the pandemic.

Recent insights from the Canadian Provinces (cont'd)

While some jurisdictions have moved ahead with more permanent policies, others are in the midst of further collecting and understanding the data to determine the impact of the temporary measures put in place, and how they may be adjusted in the longer-term.

- **British Columbia** introduced changes to their fee schedule to allow for telephone visits which are in effect until an end date can safely be determined. The province has strongly encouraged physicians to resume in-person appointments and the ministry is actively reviewing the current temporary fee codes to consider the appropriate path forward.
- **Alberta** announced its temporary virtual care billing codes are now permanent. Virtual fee codes without limitation are billed at an equal rate to face-to-face services, codes with limitation are billed at a flat fee with volume caps. On the surface there is parity between the base rates for virtual and in-person services, however, the virtual fee codes do not allow for physicians to bill for additional complexity modifiers. The issue remains at the forefront for physicians.
- **Saskatchewan** introduced pilot virtual fee codes costed using a rate of 90% of the in-person fee. This rate was settled upon through the throes of government negotiation rather than through robust data analysis to support the differential. The medical association and government will revisit this approach in March 2022.
- **Ontario** recently announced it is renewing their temporary virtual care billing codes (generally remunerated on par with face-to-face visits, but do not include payment for additional complexity modifiers) until September 2022.
- **New Brunswick** continues to offer their temporary virtual care fee codes at the same value as in-person services. These codes are set to expire in March 2022. The medical society is actively collecting aggregated utilization data by specialty, amongst other data points, to support the negotiation process.



Deloitte conducted interviews with PTMAs and government departments to understand the latest thinking, lessons learned, and paths forward in other jurisdictions as we shift towards a new, post-pandemic normal.

Synchronous Virtual Visits | Summary of Stakeholder Insights

There is a keen interest in topic area amongst physicians and stakeholders from all corners of Nova Scotia.

Engagement with Physicians (Webinar, Focus Groups)

- There was general alignment amongst more experienced virtual care users to maintain the current practice of payment parity, to not differentiate telephone vs. video, and to remove arbitrary caps while ensuring other controls to denote clinical appropriateness are in place.
- Physicians strongly expressed the modality of care should be irrelevant in determining compensation. Modality should be driven by clinical need and compensation should be driven by clinical effort.
- The overhead costs related to setup, maintenance, licenses, and devices to deliver synchronous virtual care is of concern for many physicians. Physicians believe they should receive funding to secure and maintain this overhead which enables them to deliver care.

Engagement with Health System Stakeholders

- Several stakeholders cited the following rationale for compensating synchronous virtual visits at a rate less than in-person visits:
  - Progressive adoption of virtual care reduces overhead costs for an equivalent patient roster; therefore, maintaining payment parity has the potential to increase net earnings and inequities across specialties (e.g., family physician vs. hospitalist).
  - As mentioned previously, stakeholders argue limitations associated with synchronous virtual visits reduce the value of the service, which warrants a lower rate of compensation.
- Stakeholders did not raise differences in the time and effort between virtual visits and in-person visits, which has been previously cited as a reason for deviating from payment parity.
- All stakeholders agreed compensation for virtual visits should be conditional on also providing an in-person service delivery option, to be utilized as clinically appropriate.
- Current inequities in the billing codes were also raised by select stakeholders who expressed concern that these discrepancies could be perpetuated in a permanent compensation structure if not explicitly addressed.
- Some stakeholders noted that it could be easy to "game the system" in a fee-for-service setting, whereas others expressed a desire for physician compensation to incorporate more capitation-based concepts.

Online Survey Highlights

- **The majority (75%) of physicians** indicated one of their three preferred compensation options was parity for virtual and in-person services
- **70% of physicians** feel that a virtual visit via telephone takes **more or the same amount of time** as in-person visits
- Nearly a third of physicians **(30%) indicated they do not complete virtual visits via video**
- Just over a quarter of physicians **(27%) 'do not know'** the time differential between their video and in-person visits.

Detailed survey findings are included in the Appendix.

Synchronous Virtual Visits | Summary of Stakeholder Insights (cont'd)

The innate challenges of appropriately compensating for virtual services in a fee-for-service environments were highlighted in discussions with international jurisdictions.

Engagement with Global Subject Matter Experts

- **In the United Kingdom** physicians are compensated for all services under a capitated model (as opposed to FFS). With this, there is more incentive to manage additional streams of patient contact (i.e., both synchronous and asynchronous virtual care), and provides no difference to compensation for virtual or in-person visits. COVID-19 and the need to offer more virtual services prompted NHS to invest in additional technology platforms and tools for physicians that were not in place pre-pandemic.
- These tools have also allowed for additional checks and balances – i.e., audits performed by independent clinicians on Babylon virtual visits are linked to licensure and do not happen for in-person visits.
- Patient access to virtual visits are moderated in the UK by triaging protocols that navigate patients to in-person services as appropriate for the care needs.
- **In the United States**, virtual care reimbursement through the CMS systems shifted at the onset of the COVID-19 pandemic as well. While coverage and payment parity laws vary from state to state, CMS has extended the emergency measures on telehealth access and coverage through December 31, 2023 to allow for additional time to evaluate services.
- Overall, payors in the United States are looking to make shifts towards more value-based approaches. Value-based considerations are centered around how much value (i.e., improvement in clinical outcomes or access) is observed and at what cost.
- **In Australia**, on January 1st 2022, it was announced that synchronous virtual care will be supported and continued as part of the Medical Benefit Scheme (MBS) landscape. The MBS telehealth items have the same clinical requirements as the corresponding face-to-face consultations and will list a rebate that is 100% of the equivalent in-person fee.
- To safeguard against inappropriate MBS billing, the existing "80/20" rule limiting the total professional services rendered on each of 20 or more days now includes video or telephone services. Physicians who provide more than 80 services will be referred to the Professional Services Review (PSR). Additionally, the MBS includes a new "30/20 rule" which refers any physician who provides more than 30 telephone services on 20 or more days in a 12-month period to the PSR. The Professional Services Review (PSR) is a Commonwealth agency whose role is to safeguard the Australian public from the risk and cost of inappropriate practice within the MBS. The PSR process is supported by multidisciplinary clinical teams who provide peer review of those individuals referred. The PSR can progressively sanction physicians up to full disqualification from the Medicare Program and repayment of inappropriate billing.
- Policy pundits suggest that the expansion of virtual care beyond the pandemic should be focused on improving system efficiencies through achieving 'value for money' and should trial add-on or bundled payment models that are less reliant on fee-for-service criteria.

Synchronous Virtual Visits | Reviewing the key policy issues and considerations

While there are reasonable arguments for and against payment parity, there is a limited evidentiary base that points to decisive rationale to deviate from today's status quo.

In the following section we highlight the key arguments, policy issues, and considerations for synchronous virtual visits with both insights from our stakeholders, as well as recent literature, and/or findings from other jurisdictions.

Payment parity

- The notion of payment parity for in-person and virtual visits (both telephone and video) is the most critical compensation decision relating to synchronous virtual visits. There are several reasonable, yet contradictory, arguments for and against payment parity, however, the strength of evidence to deviate from the current practice of payment parity is highly anecdotal.
- **Service overuse.** A key argument against payment parity is the potential for overutilization of virtual care visits compared to in-person care, leading to runaway health system costs. While there is limited empirical evidence assessing concerns on abuse, an Ontario study suggests that the relaxation of virtual care billing requirements through the early stages of COVID-19 were not associated with a significant increase in visit volume, however, the study notes the limited and unique circumstances in which the study took place. The true impact on health system costs will not be understood until additional data is collected in an environment that will more accurately reflect the care delivery patterns moving forward.
- **Overhead expenses.** It is believed the practice expenses associated with delivering care virtually (via telephone or video) may be lower than delivering in-person care. This view is logical when weighing complete in-person compared vs. complete virtual care (i.e., the ability to reduce office overhead), however, it is safe to assume the majority of physicians will never fully shift their practices to exclusive virtual care offerings. A recent study out of Alberta suggests that community-based FFS family physicians will experience substantial reductions in their average annual income due to practice changes through the pandemic.
- **Clinical effort.** There are many physicians who believe that virtual care requires the same clinical effort (i.e., time/duration), or more, than in-person care. While the evidence to support this claim is limited, so is the counterargument that virtual visits are shorter due to the inability to fully complete all diagnostic services (and thus, allowing for more overall visits/day). In a small UK study, the average length of in-person visits was 9.61 minutes, compared to 5.56 minutes for telephone, and 5.94 minutes for video.
- **Efficacy of care.** There is a reasonable argument to be made that virtual visits are inherently less valuable to providers and therefore, the system, due to the inability to perform comparable clinical tasks (e.g., physical examinations). Some would describe both phone and video consults to be less "information rich" than the face-to-face alternative, whereas other would describe the enhanced ability to interact with a patient in their home environment allows for a greater quality of care. Overall, it should be noted that the effectiveness of virtual care cannot be generalized, and the mode of delivery (i.e., in-person, video, telephone) should not be used to distinguish high-value and low-value care. A better understanding of long-term clinical outcomes is required. Physicians should determine the modality based on the clinical appropriateness of the situation.

Evidence Based Policy Making

The following standards were applied in considering whether evidence supported deviating from payment parity for virtual; visits:

- **Strong Evidence:** Congruent findings from multiple deliberately designed pilot programs/studies.
- **Some Evidence:** Congruent findings from multiple ad hoc or retrospective analyses of the cost efficacy of virtual services.
- **Weak Evidence:** Anecdotal and experiential evidence based on quantitative analysis limited in scope or representative data.

Our analysis generally found incongruent "weak" evidence sources with select examples of "some" evidence.

Synchronous Virtual Visits | Reviewing the key policy issues and considerations (cont'd)

Physicians should be trusted to select visit types based on their best clinical judgement; policy should ensure virtual care services are complimentary to in-person offerings.

Differential compensation - telephone vs. video

- In a report commissioned by the Federal Provincial Territorial Virtual Care Table, Will Falk's early diagnostic and policy recommendations provided a $1 Messaging: $3 Phone: $5 Video: $5 in-person ratio across modalities, amongst other fee-for-service considerations. This ratio, while only informed by qualitative interviews, suggests a higher fee for video vs. telephone visits. However, the view that a telephone visit cannot inherently be as valuable or as effective as a video visit is not supported by robust clinical evidence.
- Concerns around inequitable access for patients is the leading argument against differentiating rates between telephone and video visits. The patients who typically engage in telephone visits may often be from more rural areas where video may not be an option. Further to this, patients may have digital literacy challenges, amongst other access issues that could limit their ability to engage with providers via video.
- With this, unless evidence becomes available to demonstrate the greater clinical value of a video visit over a telephone visit, maintaining parity between the modalities prevents a potentially unnecessary increased use of video over an equally effective telephone visit caused by differential rates, and supports accessible, inclusive care for patients.

Volume capping

- Volume capping, or limiting the number or percentage of virtual visits physicians can provide, is a compensation-related issue specific to virtual visits in the Nova Scotia context. Implementing volume-based restrictions is typically driven by the concern of potential increases to overall health system costs, and a potential decrease in the provision of in-person care negatively impacting patient outcomes. Various forms of caps have been implemented in some jurisdictions, all generally mandating how many visits or exchanges can be billed within a given period of time:
  - Prior to the pandemic, physicians in Prince Edward Island were limited to 14 virtual visits per week.
  - Similarly in Newfoundland & Labrador physicians are limited to 40 virtual visits per day.
  - As part of Saskatchewan's Family Practice Virtual Care Pilot the Ministry enabled a 3,000 per year service limit on virtual visits (on a prorated basis effective in July 2021) where physicians are notified when they reach 80% of the billing limit.
- Depending on the thresholds included in the cap, some physician specialties will be more negatively impacted than others based on their practice patterns (i.e., the amount of virtual care that can be provided varies significantly by specialty, and more rigid caps may have less consequence on some).
- The notion of limiting the number of virtual services that can be provided has not been overly well-received by many physicians in the province. Physicians feel, as licensed medical professionals, they should be trusted to use their clinical judgement to determine the visit type and should not be limited in this selection within a given time period. This approach to choosing a service modality would be consistent with other physician decisions (e.g., ordering diagnostics, admitting or referring patients) that have financial implications but are not regulated by the Province. That said, it is recognized that while some control mechanisms are important to ensure appropriate care is being delivered and patients are able to access services in-person, blunt policy instruments such as volume caps should not be arbitrary.

Synchronous Virtual Visits | Reviewing the key policy issues and considerations (cont'd)

While not explicitly covered within the scope of this work, issues around virtual walk-in clinics were raised throughout our consultation process, and therefore compensation for virtual walk-ins must be considered.

Virtual walk-in clinics

Although not explicitly included in the scope of this project, the issues surrounding virtual walk-in clinics were raised throughout our consultation process (i.e., the difficulties balancing continuity of care with improved patient access). The role of virtual walk-ins within the Nova Scotia health system is not clear to physicians, or patients looking to access services. With this, we have included a synthesis of key findings relating to compensation for virtual walk-ins from our 2020 virtual care compensation work with the Atlantic PTMAs:

- Jurisdictions have approached remuneration for virtual walk-in visits differently:
  - In New Brunswick, virtual care is available in the private walk-in clinic setting. The province remunerates walk-in clinics for virtual visits at a rate of $18.50 lower than primary care providers, resulting in a significant fee differential.
  - PEI remunerates virtual walk-in visits through Maple, with a right of first refusal for physicians in PEI. Newfoundland and Labrador has also had many patients served through Maple.
  - Nova Scotia has specifically excluded walk-ins from virtual care fee codes and yet Nova Scotia Health has established a VirtualCareNS program that provides virtual care for unattached patients. The program is not intended to be a long-term solution for unattached patients, but rather to serve as a bridge until patients are able to be more formally rostered.
  - In Alberta, walk-in clinics, such as Babylon, are not excluded from the new COVID-19 fee codes for billing virtual services.
  - British Columbia compensates virtual walk-in visits at the same rate as regular virtual visits and face-to-face visits.
  - In Ontario, walk-ins are excluded from virtual care fee codes through restricted registration and billing on the Ontario Telehealth Network (OTN) platform to certain parties.
- One of the common concerns raised by critics of virtual walk-in visits is the risk of fragmenting primary care and undermining the physician-patient relationship. Because virtual visits improve timely patient access to care, some patients may choose to seek out virtual walk-in clinics to avoid waiting for an appointment with their primary care provider. Making virtual walk-in visits more accessible through remuneration heightens the worry that attached patients will substitute virtual walk-in visits for visits with their own family physician, generating opportunities for fragmented care.
- There is further complexity when considering unattached patients that do not have a family doctor to go to. Not compensating physicians for virtual walk-in visits may put the region's unattached patient population at disproportionate risk by forcing them to seek care in person during a global pandemic.

Synchronous Virtual Visits | Summary of recommendations

This page summarizes physician compensation recommendations in relation to synchronous virtual visits.

Recommendation	Description
1. Maintain temporary practice of payment parity	• Government should continue to allow for synchronous virtual visits to be billed on-par with in-person visits over an extended temporary time horizon (i.e., a minimum of two years or until a sufficient evidentiary base has formed) to provide physicians certainty in their practice planning, and to allow for the use and impacts of virtual care to be assessed prior to making a decision around permanency of fee structures. • While there are reasonable, yet contradictory, arguments to deviate from payment parity there is a limited evidentiary base that points to decisive rationale to deviate from today's status quo. • It is too soon to make evidence informed decisions, and a permanent decision should be deferred until the evidence can be further collected and the impact of the payment parity policies are better understood.

2. Ensure appropriate data collection mechanisms are in place	• During this time, Government should ensure the appropriate data collection mechanisms are in place to allow for robust system-wide data collection on the utilization of telephone/video visits across specialty areas as part of their total case mix, and the impact on overhead expenses.
	• Such data collection mechanisms should include:
	  • The creation of temporary virtual care fee codes and/or stricter enforcement of text modifiers on existing face-to-face codes to prevent under reporting of virtual care utilization and services across specialties.
	  • Conducting analysis to measure the impact on clinically appropriate virtual care adoption on physician overhead expenses.
	  • Ongoing patient and provider feedback.

3. Assess the data points collected	• Once sufficient evidence has been gathered, Government should reevaluate payment parity between face-to-face and virtual visits, and between video and telephone virtual visits to determine permanent payment structure(s) and fee codes. • The relative clinical value of different exchanges across specialty areas should be assessed, as well as materially significant differences in health system costs that would warrant differential rates to be established.
4. Ensure the appropriate monitoring and accountability mechanisms are in place	• Government and DNS should work together to ensure the appropriate monitoring and accountability mechanisms are in place to complement the existing policies on the provision of virtual care. • Monitoring mechanisms should leverage data analytics for peer group reporting (e.g., within specialties, care settings, geographies, etc.) and to identify significant outlier patterns of physician virtual care utilization, while also identifying leading practices. Outliers that may be deemed to negatively impact on patient care, may then be subject to practice audits or subsequently referred to existing mechanisms for holding physicians accountable for sound professional judgment. • All volume caps/restrictions introduced during the pandemic on the provision of virtual care, in relation to in-person care, should be phased out once monitoring mechanisms are in place. • While the relative mix of in-person to virtual services may vary greatly by specialty, policies should ensure patients have the ability to access services in-person (other than 811 triage or emergency departments), if required and/or desired within a reasonable timeframe.
5. Address inconsistencies relating to virtual walk-in services	• To address the confusion with virtual walk-in services in the health system today, Government and DNS should work together towards a solution for virtual walk-ins that will meet the needs of patients and providers. • The inconsistency in how virtual walk-in services are offered across the province (i.e., VirtualCareNS pilot for unattached patients vs. traditional walk-in clinics' inability to offer virtual services) has frustrated providers and patients alike. Any approach to compensating virtual walk-in services should carefully consider supporting continuity of care in primary health.

Asynchronous Provider to Patient (Secure Messaging)

Secure Patient Messaging | Nova Scotia Context

Compensation is a barrier limiting physicians from better leveraging secure patient messaging to create new capacity and improve patient access.

Today's context

- Nova Scotia does not currently have funding in place to support secure provider to patient messaging. In March of 2020, the previous MyHealthNS provincial pilot program concluded, as the online platform was no longer available to physicians or patients.
- The MyHealthNS pilot program provided up to a quarterly $3,000 Virtual Care Technology Incentive Stipend for physicians who agreed to enroll patients in the MyHealthNS program. The program enabled a release of e-results to patients, and also provided a platform to communicate asynchronously with patients, with a goal that all patient messages would be addressed within two business days.
- An analysis of the program concluded that physician capacity gains of up to 14% could be achieved by responding to routine patient questions via secure messaging versus in-person visits, and that as many as 22% of office visits could be addressed through messaging.
- Following the conclusion of the program, many physicians chose to implement their own solutions via their EMRs (i.e., Health Myself / Pomelo, Medeo, etc.) or have resorted to 'insecure' methods to continue messaging with their patients.
- This service is commonly used in the primary care environment where patients have established relationships with their physicians, however, can be extended to specialty care as well. Physicians who have continued to offer this access to their patients no longer receive compensation for the asynchronous care they are providing.
- There is some concern amongst physicians to introducing secure messaging within their practice, particularly around the potential for patients to misuse the messaging for urgent issues and/or frequent interaction. This could further impact physician burnout and calls for clear boundaries to be set.
- However, with the appropriate supports and guidance in place to address these concerns, there is a significant opportunity to support the continued use and broader adoption of secure patient messaging by implementing a compensation approach that will appropriately renumerate physicians for their time spent providing asynchronous care to their patients.

Focus of section - The key policy question we seek to address:

Which compensation options will appropriately renumerate physicians for asynchronous secure patient messaging within the context of wider health system change in Nova Scotia and the priorities of the government (i.e., alignment to guiding principles)?

Secure Patient Messaging | Overview

We have consolidated potential compensation model options for secure patient messaging to be evaluated for the purpose of developing tangible compensation recommendations.

Overview

- Secure patient messaging includes text, email, or portal based deferred communication between patients and their physicians. It is viewed as a tool to significantly improve patient access, with the potential to replace in-person visits.
- The modality is used extensively in international jurisdictions where physicians are renumerated under capitated model (e.g., Kaiser Permanente in the United Statement reported 31 million secure messages between patients and providers in 2018, and in the United Kingdom the NHS offers a number of asynchronous tools to support offline streams of contact between patients and providers). From a Canadian perspective, the Enhanced Access to Primary Care (EAPC) initiative in Ontario serves as a leading case study to demonstrate the applicability of the service. 90% of the encounters in this program used asynchronous messaging, and 81% of overall visits required no additional follow-up. On average, providers sent 3.2 messages and patients sent 2.4 messages per visit, which sometimes took place over multiple days. Physicians believed the effort of these asynchronous visits were similar to in-person and felt that compensation should be similar as well. Physicians are however highly cognizant of the potential for burnout in the absence of clear boundaries with patients accessing this services (i.e., response time expectations and volume of messages). With this, it is critical that physicians are compensated appropriately for their time spent leveraging this modality.
- While there are a range of permutations and variables which exist within the compensation models highlighted below, we have synthesized these options into three distinct compensation approaches for purposes of our evaluation. These approaches were leveraged in our engagement across stakeholder groups.
- In the pages that follow we present the insights gleaned from our stakeholders as it relates to the potential impact of reintroducing secure patient messaging programs, as well as their views on the range of applicable compensation options. We then provide a deeper analysis of each of the options highlighted below, articulating their use in other jurisdictions, key benefits and challenges, and overall alignment to our guiding principles.

Flat fee	Time-based units	Stipend
• Physicians are compensated at a flat rate per message/exchange to patients. Flat fees can be modified depending on the complexity of an interaction towards a tiered fee structure. • *Per resolved issue:* Physicians can be compensated at a different rates for each issue resolved or visit closed via asynchronous care methods, as opposed to each message.	• Physicians are compensated at a certain rate per specified unit of time taken to complete each message/exchange/encounter irrespective of the number or complexity of interactions.	• Physicians are compensated a fixed annual or monthly sum for providing care based on certain conditions. • *Tiered:* Physicians can be compensated at multiple levels of remuneration depending on volume of use, patient enrolment, etc. This could mean payment for a fixed number of hours per week, or alternatively, stacked thresholds based on volume of encounters.

Secure Patient Messaging | Summary of Stakeholder Insights

There is no clear physician consensus on a preferred compensation model for secure patient messaging.

Engagement with Physicians (Webinar, Focus Groups)

- Secure messaging was recognized by physicians as a tool to replace some in-person visits, particularly very low acuity care needs or routine services.
- Physicians recognize the flexibility of secure messaging provides their patients - it minimizes unnecessary travel costs, and saves significant time by not disrupting their daily life. However, the access and convenience benefits to patients needs to be carefully weighed against physicians' ability to set appropriate boundaries so as to avoid burnout.
- From a compensation perspective - simplicity and limiting administrative burden were the most critical factors in selecting a long-term compensation model.
- There was no clear consensus preference between the described compensation models, however, physicians found it difficult to envision how time-based units or 'per message' approaches would be tracked in the absence of sophisticated technology.
- Stipends were viewed as a logical starting place to further our understanding of physician utilization, key system benefits, and barriers to adoption.

Engagement with Health System Stakeholders

- Stakeholders we consulted expressed a preference toward a stipend-based approach to compensating physicians for Secure Patient Messaging. This stipend could be tiered based on caseload complexity and require reporting minimum service volumes to MSI.
- Low administrative burden was cited as the primary rationale; several stakeholders had concerns about defining service units or a time-based measurement.
- Stakeholders also felt this compensation model was a step toward a blended capitation approach.
- Some stakeholders did express reservations about committing to a permanent stipend for Secure Patient Messaging based on the relative value of the modality within a fixed budget envelope for physician services.

Online Survey Highlights

- **94% of physicians** believe asynchronous secure messaging with patients should be compensated. However, there is no clear consensus on a preferred compensation model:
  - **39% of physicians** selected a flat fee per message/exchange as one of their top three
  - **36% of physicians** selected a time-based approach as one of their top three
  - **27% of physicians** selected a fixed stipend as one of their top three
- Physicians overwhelmingly noted the positive or very positive impact compensating for secure patient messaging will have on the patient
  - **89% of physicians** indicated a positive or very positive impact to patient costs (i.e., travel time, time off work, etc.)
  - **84% of physicians** indicated a positive or very positive impact to patient engagement/satisfaction
- However**, the majority of physicians (52%)** indicated a negative or very negative impact to physician administrative burden and **just over one third of physicians (37%)** indicate a negative or very negative impact to physician burnout.

Secure Patient Messaging | Reviewing applicable compensation options

Adopting a fee-for-service approach to Secure Patient Messaging would require a clear definition of the unit of service and may unintentionally incentivize inappropriate utilization.

Flat fee approach

- A flat fee approach to compensating physicians for secure messaging with patients replicates traditional fee-for-service billing. Flat fees can be further modified depending on the complexity of an interaction towards a more tiered structure, similar to in-person visits. As part of our work we assessed two predominant permutations of flat-fee-based compensation options for secure patient messaging:
  1. A flat rate per message/exchange.
  2. A tiered fee per resolved issue (as opposed to each message).
- Both of these options have been implemented and/or are in use in other jurisdictions:
  - British Columbia uses a flat fee approach to compensating for physicians who use email or text messaging to provide medical advice to a patient, or delegates this task to a medical office assistant or other allied health provider in the office. Physicians are compensated $7.00 for relaying the medical advice, up to a maximum of 200 claims per year. Physicians are appreciative the code exists, however, the medical association feels the code may be too low as it currently exists, and is not used extensively.
  - Ontario renumerates physicians using a tiered fee-for-service approach (depending on the complexity of the interaction per resolved issue) in their EAPC initiative. Minor assessments were compensated at $15.00 ($2.25 capitation) and intermediate assessments were compensated at $21.70 ($3.25 capitation).
- Beyond being supported by use cases in other jurisdictions, there are several benefits to this approach, many of which in line with our guiding principles:
  - Compensating physicians for the ability to address and resolve patient issues asynchronously is highly aligned to system access objectives, and clearly demonstrates the ability for asynchronous exchanges to replace in-person visits, promoting high for value for money.
  - The ability to tier fees based on the complexity of an interaction allows physicians to be more accurately compensated for the clinical effort required to complete the exchange.
- Despite the benefits, there would be several challenges to overcome should either flat fee approaches be implemented:
  - First and foremost, clarity in defining units of service is required (i.e., what constitutes a message, exchange, or a resolved issue?). This is not simple for physicians to understand as it stands today.
  - While the tracking of messages/exchanges is in line with traditional fee-for-service models, the additional element of tracking resolved issues is thought to be highly administratively burdensome for physicians.
  - Beyond this, a per message/exchange flat rate incentives physicians to drive volume – potentially jeopardizing the quality of interactions and negatively impacting the system's value for money and cost certainty.
- Overall, tiering flat fees based on complexity per resolved issue has greater alignment to guiding principles than a flat fee per message/exchange approach.

Secure Patient Messaging | Reviewing applicable compensation options (cont'd)

A time-based compensation approach could be administratively burdensome, whereas a stipend-based model would be simple and consistent with previous pilot programs in Nova Scotia.

Time-based approach

- The second option we assessed to compensate physicians for their time spent securely messaging with patients was a time-based units approach. In this model, physicians are compensated at a certain rate per specified unit of time taken to complete each exchange with patients over a given period, irrespective of the number or complexity of interactions.
- While time-based options are not used in any of the Canadian jurisdictions we reviewed, it is leveraged in the United States. Physicians in the CMS system have the ability to bill for check-ins and e-visits conducted using a secure messaging platform. Compensation is based on the cumulative time it takes to provide services over a seven-day period and ranges from $13.35 to $50.16.
- In theory, compensating physicians for their actual time spent (i.e., clinical effort) asynchronously communicating with their patients is ideal. However, when considering the practicalities of implementing this approach it quickly becomes quite complex and unattractive.
  - The administrative burden associated with tracking time spent on each interaction is daunting. For example, the need to record start and stop times of reading and writing messages, possibly spread out over a number of days, in addition to any time spent researching or reviewing documentation to inform responses, would be very difficult.
  - Time tracking would be a new administrative activity for many physicians.
  - Some physicians noted that if sophisticated technology was available to support the tracking, it may be less burdensome and easier to manage.
  - Additionally, compensating for time-based units may incent physicians to spend as long as possible on each exchange, ultimately hindering any value for money efficiencies, and limiting system cost certainty.
- Overall, a time-based approach to renumerate physicians has limited alignment to guiding principles.

Stipend-based approach

- Finally, our third compensation option for physicians who securely message with their patients is a stipend-based model. In this option physicians are compensated a fixed annual or monthly sum for providing care based on certain conditions.
- Physicians can be compensated at multiple levels of remuneration within the stipend depending on volume of use or patient enrolment. This could mean payment for a fixed number of hours per week, or alternatively, stacked thresholds based on the volume of exchanges, etc.
- As previously described, Nova Scotia has implemented a stipend-based model to compensate physicians for secure patient messaging in the past. The Virtual Care Technology Incentive Stipend provided up to a quarterly $3,000 for physicians who enrolled patients on the MyHealthNS platform. Analysis of the program revealed encouraging results relating to patient access and physician capacity.

Secure Patient Messaging | Reviewing applicable compensation options (cont'd)

A stipend-based approach to compensating physicians for Secure Patient Messaging when each candidate model was evaluated against the guiding principles.

Stipend-based approach (cont'd)

- Physicians were generally favourable towards stipend-based models throughout our consultation process. Several advantages of the approach include:
  - Limited administrative burden for physicians on a day-to-day basis as little to no tracking is required;
  - Provides flexibility for physicians to explore how to best use the tool; there is no limit on the number of interactions; and
  - Provides the highest degree of cost certainty compared to other models.
- There are however disadvantages with the stipend-based approach:
  - Potentially over/under compensating physicians depending on their overall usage. Even with volume-based thresholds as part of the stipend, higher volume users may not be adequately compensated compared to lower volume users.
  - In a similar vein, there is little ability to drive accountability for lower volume users - limiting the positive impacts to patient access to be had.
  - Inability to capture complexity, or clinical effort associated with each interaction.
- Under a stipend-based model understanding overall service utilization and uptake amongst physicians is critical in appropriately determining the size of the overall funding envelope.

Alignment to Guiding Principles

	Strategic Alignment	*Modality Neutrality*	*Low Admin Burden*	*Value for Money*	*Cost Certainty*	*Feasibility*	*Overall*
Flat fee / message or exchange	3	1	3	1	1	2	**11**
Tiered fee / resolved issue	5	4	1	5	2	3	**20**
Time-based units	1	1	1	1	2	2	**8**
Stipend	2	3	5	4	5	5	**24**

1 = No alignment 5 = Strong alignment

- The scores above summarize the assessment of compensation options against project guiding principles. Each option was given a score of 1 through 5 based on the degree of alignment to the principles. This assessment was done collaboratively with our SC and leveraged the insights and feedback provided through our data collection phase.
- Overall, a stipend-based approach was most aligned to project guiding principles, followed closely by tiering flat fees based on complexity per resolved issue. A flat fee per message/exchange approach was slightly more aligned to guiding principles than compensating via time-based units.

Secure Patient Messaging | Summary of recommendations

This page summarizes physician compensation recommendations in relation to secure patient messaging.

Recommendation	Description

1. Re-establish a stipend-based model to compensate physicians for asynchronous secure messaging with their patients	• Government should re-establish a stipend-based model to compensate physicians for asynchronous secure messaging with their patients.
	  • The stipend-based model should include the ability for a tiering of fees to allow for physicians to be compensated at multiple thresholds based on factors such as caseload complexity, number of patients utilizing the service, or patient message volumes.
	  • Physicians value simplicity. Ensuring there is limited additional administrative burden placed upon them is critical when selecting a preferred compensation approach. Stipend-based models are positively recognized for this characteristic by physicians, and were also identified as a highly feasible option with significant cost certainty when assessed against virtual care compensation guiding principles.
	  • A stipend-based approach to secure patient messaging will encourage adoption by physicians and patients, and will help prevent overuse - a concern that is common with fee-for-service approaches. Of note, asynchronous secure messaging with patients is focused on non-emergent care.

2. Work together to inform development of the stipend	• To inform the development of the stipend, DHW and DNS should work together to advise on anticipated service utilization and required service volumes, as well as other critical enablers to support broad physician adoption.
	  • In addition to ensuring a straightforward compensation model is in place, physicians will require broader support in other areas to ensure successful implementation of the modality in their practice (e.g., technology platforms, change management, training, support managing patient expectations, etc.).
	  • Additional detailed design (e.g., financial analysis, business case development, etc.) will be required to ensure stipend development is appropriately aligned with the overall budget for Physician Services and the fiscal priorities of the Government.

Asynchronous Provider to Provider (E-Consults)

E-Consults | Nova Scotia Context

Nova Scotia is one of the only provinces that does not support e-consults between family physicians and other specialists.

Today's context

- Nova Scotia and PEI are the only provinces in the country that do not support a formal e-consult program. Nova Scotia, however, has recently launched a proof-of-concept e-consult program using Ocean/Cognisant MD, which will compensate both primary care providers and specialists via stipends (calculated based on expected volumes during the proof-of-concept).
- As part of the 2015 Master Services Agreement with DHW, new telephone health services codes were introduced, including the ability for family physicians and specialists to bill for physician-to-physician synchronous phone interactions that are charted in the patient's record (i.e., 03.09L and 03.09K). These interactions must be accompanied by documentation by the family physician, and charted by both the requesting and the consulting physician for billing purposes.
- While these synchronous codes were a critical first step in enabling timely advice between family physicians and specialist, they do not compensate for any such clinical advice provided asynchronously.
- Despite the lack of appropriate codes, a pilot program using MyHealthNS (Relay Health) was successful for general internal medicine. In this program, all participating internists were compensated under an Academic Funding Plan. As of March, 2020, the MyHealthNS solution was no longer available in Nova Scotia.
- It should be noted that not all physicians understand the concept of e-consults compared to the synchronous provider-to-provider codes, in part due to confusion around the term 'consult'.
- However, beyond this, the potential for positive impacts across the health system, particularly as it relates to reducing wait times for specialty care, are generally agreed upon.
- In a similar vein to compensating for asynchronous provider to patient virtual care via secure messaging, with the proper education and change management supports, compensating physicians for e-consults represents a significant opportunity to capitalize on existing expertise in the system to reduce unnecessary referrals to specialty care.

Focus of section - The key policy question we seek to address:

Which compensation options will appropriately renumerate physicians (both requesting and consulting) for the completion of e-consults within the context of wider health system change in Nova Scotia and the priorities of the government (i.e., alignment to guiding principles)?

E-Consults| Overview

We have consolidated potential compensation model options for e-consults to be evaluated for the purpose of developing tangible compensation recommendations.

Overview

- E-consults are provider to provider asynchronous exchanges from a requesting physician (typically, but not exclusively, a primary care provider) to a consulting physician (typically a specialist), relating to the provision of care of a patient. The nature of the exchange is not with the intent to handover a patient to the consulting physician, but rather, looking for clinical advice to support the provision of care of a patient. With this, e-consults are an innovative mechanism to support patient access to specialist physician services and collaboration with other providers.
- When used appropriately they have the ability to reduce unnecessary referrals, and ultimately decrease wait times for specialty care. For some, the term 'e-consult' can be confused with providing synchronous virtual visits – in some jurisdictions the modality is referred to as tele-expertise. E-consults are viewed favourably by physicians who understand their use case and potential system benefits. Choosing the optimal compensation models for e-consults is critical in order to encourage physician adoption, and timely and quality specialist response times.
- Compensation decisions for e-consults are different than other asynchronous modalities, such that there are two physicians who may warrant reimbursement for their efforts. With this in mind, the requesting and consulting physician need not be compensated via the same model. For requesting physicians, some view e-consults as an additional task as part of the patient's visit or part of the physician's duty of care to complete, and thus, should not be compensated. However, most physicians agree that requesting physicians should be renumerated for their time spent sending the consult, following through on specialist recommendations and ultimately managing the conditions of the patients, as opposed to simply referring the patient to specialty care. Other jurisdictions that have more mature e-consult programs employ a variety of payment models, ranging from pro-rated hourly fees for the length of time spent answering a consult, to traditional fee-for-service rates, to flat weekly stipends.
- Similar to our approach with secure patient messaging, we have synthesized compensation options into three distinct approaches below. In the pages that follow we present the insights from our stakeholders on the models, as well as a deeper assessment of each of the highlighted approaches.

Flat fee	Time-based units	Stipend
• Physicians are compensated at a flat rate per e-consult sent/completed with other providers. • *With incentives:* Incentives can be added to flat fee approaches (i.e., e-consults addressed in a given time window).	• Physicians are compensated at a certain rate per specified unit of time taken to complete an e-consult irrespective of the number or complexity of the consult. • *With incentives:* Physicians can be compensated a bonus of a dollar amount to complete a service within a specified window of time, in addition to the standard hourly rate (e.g., $10 bonus for completion within 24 hours).	• Physicians are compensated a fixed annual or monthly sum for providing the service based on certain conditions. • *Tiered:* Physicians can be compensated at multiple levels of remuneration depending on volume of use, or other factors. This could mean payment for a fixed number of hours per week, or alternatively, stacked thresholds based on volume of consults.

E-Consults | Stakeholder Insights

There is no clear consensus on a preferred compensation model for e-consults.

Engagement with Physicians (Webinar, Focus Groups)

- For some, e-consults are an important mechanism for supporting patient access to specialist physician services and collaboration with other providers, however, others struggle to understand the concept.
- The potential access and clinical outcomes of e-consults are viewed favourably by physicians; however, there is some concern about the potential for e-consults to be administratively burdensome.
- That said, it is generally recognized that both the requesting and consulting provider should be compensated for the exchange.
- E-consults, by their nature, involve varying degrees of complexity and clinical uncertainty, which suggests any fee-for-service or stipend compensation approach may benefit from a tiered approach based on complexity.

Engagement with Health System Stakeholders

- Stakeholders we consulted expressed a preference toward a fee-for-service approach for e-consults, where both the requesting and consulting physician would be compensated for the exchange.
- Recognizing that other health professionals may request a consult to a physician, it was suggested that both family practice and specialist physicians could fulfil the role of the consulting physician. This model would also support other health providers working to their full scope of practice.
- Stakeholders also suggested that billing codes for e-consults should be tiered to reflect case complexity and should include incentives for timely responses.

Online Survey Highlights

- **92% of physicians** believe the referring provider should be compensated for e-consults; **95% of physicians** believe the consulting physicians should be compensated.
- **The majority of physicians (51%)** selected a flat fee for e-consult as on of the preferred option for compensation referring physicians; **only 16%** selected a type of stipend-based model (fixed/tiered)
- Similarly, **only 14% of physicians** selected a type of stipend-based model as a means to renumerate consulting physicians; there is no clear preference amongst between physicians between flat fee and time-based approaches
- The majority of physicians indicated that appropriately compensation would have a positive or very positive impact on most categories:
  - E.g. **86% of physicians** indicated a positive or very positive impact on coordination of care
  - E.g. **78% of physicians** indicated a positive or very positive impact on clinical outcomes
- Access to primary care, and physician administrative burden were the exceptions – where majority of physicians did not indicate a positive or very positive impact:
  - E.g. **45% of physicians** indicated e-consults have no impact on access to primary care
  - E.g. **41% of physicians** indicated e-consults will have a negative or very negative impact on physician administrative burden

E-Consults| Reviewing applicable compensation options

A flat fee approach to compensation for e-consults would be consistent with existing synchronous compensation model for provider-to-provider exchanges.

Flat fee approach

- A flat fee approach to compensating physicians for e-consults, renumerates requesting and/or consulting physicians per e-consult sent or received. Within a flat fee approach, incentives can be added for consulting physicians to provide a premium rate for e-consults addressed in a given time window.
- This approach is commonly used in other jurisdictions, as it mirrors existing fee-for-service structures:
  - Alberta renumerates both requesting and consulting physicians through flat fees with separate codes and rates – referring physicians are billed just under 50% of the consulting physician rate. There are no fee modifiers are in place for either code.
  - In a 2016 Ontario study, the cost effectiveness of a flat fee model for e-consult was also explored. In this study, consulting physicians were paid a flat fee of $44.50 per e-consult, regardless of how long it takes to complete. Additionally, requesting were remunerated $16.00 for sending the consult.
- As described, an existing fee structure exists for provider-to-provider synchronous consults in Nova Scotia. The ability to replicate a similar fee structure for consults completed asynchronously represents a significant advantage of this compensation model.
- A flat fee model for both requesting and consulting physicians also allows for a requesting physicians to send e-consults to a specialty group (rather than an individual specialist) as a means of centralized intake. The e-consult can then be assigned or selected by a specialist based on their availability.
- For consulting physicians flat fee models are less flexible for complex consults, which may require additional time to complete. The additional clinical effort or time spent on these interactions are not recognized. However, very few disadvantages were identified, for both requesting and consulting physicians, through our analysis.
- A flat fee per e-consult with a time-based incentive is highly aligned to system strategic objectives, and feasible from a technical, financial, and political standpoint given the fee schedule in place today.
- As a traditional fee-for-service model, a reasonable level of cost certainty is assumed, particularly for incentive-based flat fees. It is agreed that broad physician adoption of this service will take time, and thus, the potential for runaway system costs are minimal. However, both options provide strong value for money.
- Similarly, the associated administrative burden for a flat fee (without incentive) model would be relatively low, in line with physicians existing billing structure. For models with time-based incentives the administrative burden may be somewhat higher.

E-Consults| Reviewing applicable compensation options

A time-based compensation approach for e-consults would be highly administratively burdensome relative to other compensation models.

Time-based approach

- A time-based approach compensates physicians a certain rate per specified unit of time, pro-rated to the length of time taken to complete each e-consult. This approach allows for incentives to be added (e.g., a higher hourly rate) if incentives are responded to within a given time period.
- Similar to a flat fee model, a time-based compensation approach also allows for e-consults to be sent to a centralized intake, as opposed to an individual specialist. This is the model leveraged in Ontario, as described below:
  - The leading e-consult program in Canada, Ontario's Champlain BASE™ eConsult program, introduced in 2010, uses a pro-rated hourly fee to compensate specialists for the services (i.e., $200/hour for the length of time spent responding to a consult). This model has been used since the inception of the program. It should be noted that requesting physicians in this program are compensated using a flat fee approach.
- Time-based approaches to compensation are primarily considered for the consulting physician. It is difficult to imagine the appropriate use case where a requesting would warrant compensation through a time-based model, particularly when response-based incentives are included. However, for the purposes of this review we explored the construct with stakeholders as part of our analysis.
- An Ontario study comparing models of renumeration for specialists completing e-consults concluded that a pro-rated hourly rate model was found to be the most cost effective with a system cost of a system cost of $45.72 per e-consult, compared with $51.90 (pro-rated incentive model).
- Despite its use in other jurisdictions, and the view that is allows specialists to be appropriately compensated for overall clinical effort, our assessment found there to be many disadvantages with the model in relation to our guiding principles.
- A time-based approach, even with an incentive for faster specialist response times, provides little cost certainty, and loses the efficiencies and value for money in relation to other models.
- From an administrative burden standpoint, a time-based model is considered to be very burdensome. Similar to the concerns for asynchronously messaging with patients, the ability to record start and stop times, that may be spread over a number of days and may include multiple exchanges with a provider, can become very difficult to track and contradicts physicians desire for simplicity.

Stipend-based model

- Lastly, we explored a stipend-based model to renumerate requesting and/or consulting physicians for completing e-consults. In this model, physicians are compensated a specified annual or monthly sum for completing e-consults, regardless of the number they complete or the complexity of the consult.

E-Consults| Reviewing applicable compensation options

Flat-fee approaches are most aligned to guiding principles, followed by a stipend-based approach and time-based units.

Stipend-based approach (cont'd)

- We assume in this approach that stipends could also be tiered with multiple thresholds to more accurately represent the overall effort, or volume of e-consults completed (i.e., a given number of hours or e-consults set for each threshold).
- Overall, stipends were recognized for their relative simplicity and lower administrative burden in relation to other models. The also present the greatest cost certainty for the system, despite the potential to over/under compensate specialists based on the volume of consults they receive and complete.
- That said, we score stipends as moderately aligned to guiding principles from a value for money perspective – assuming on balance the benefits achieved would outweigh the fixed envelope of funding allotted to the service. However, there is evidence from other Ontario that suggests a low value for money in this approach:
  - In the 2016 study previously mentioned, stipend models were found to be the least cost effective across evaluated compensation options with a system cost of $337.44 – approximately 750% higher than the most effective option (pro-rated hourly).

Alignment to Guiding Principles

	Strategic Alignment	*Modality Neutrality*	*Low Admin Burden*	*Value for Money*	*Cost Certainty*	*Feasibility*	*Overall*
Flat fee per E-Consult	4	5	5	4	3	5	26
Flat fee with incentive*	5	4	4	5	3	4	25
Time-based units	1	1	1	1	1	1	6
Time-based units With incentive*	1	1	1	1	1	1	6
Stipend	3	2	4	3	5	3	20

1 = No alignment 5 = Strong alignment *Only applicable for consulting physicians

- Similar to our approach for scoring secure patient messaging, compensation options for e-consults were assessed with our SC and scored in alignment to project guiding principles.
- In this assessment, we considered the nuances between requesting and consulting physicians, and determined the relative scores to be unchanged between the two.
- Flat-fee approaches are most aligned to guiding principles, followed by a stipend-based approach, and time-based units.

E-Consults | Summary of recommendations

This page summarizes physician compensation recommendations in relation to e-consults.

Recommendation	Description

1. Introduce a flat fee compensation model with unique fee codes for both the requesting and consulting physicians	• Government and DNS should work together to introduce a flat fee compensation model with unique fee codes to compensate both the requesting and consulting physicians for completing e-consults.
	  • It is widely recognized that both the requesting and consulting provider should be compensated for the exchange. Like secure patient messaging, simplicity was valued above all for physicians. When assessed against guiding principles, flat fee compensation models for e-consults provide a highly feasible, simplistic approach that serves as a natural extension of the existing synchronous remote consult fees. The current rate for synchronous provider-to-provider consults (i.e., Health Services Codes 03.09L and 03.09K) provides a clear starting point for developing asynchronous codes for e-consults.
	  • For requesting physicians, e-consults should adopt a flat fee model, per e-consult.
	  • For consulting physicians, e-consults should adopt a flat fee model with time-based conditions (i.e., services can only be billed when e-consults have been responded to within a given timeframe).
	  • Primary care physicians should be eligible to be the consulting physician when the requesting party is a non-physician health care provider (e.g., a duty nurse providing care to a resident in long-term care), or when the consulting physician has an identified functional specialty area within family practice (e.g., geriatrics, opioid treatment, etc.).
	  • Additional detailed design (e.g., financial analysis, business case development, etc.) will be required to ensure fee development is appropriately aligned with the overall budget for Physician Services and the fiscal priorities of the Government.

2. Evaluate the implementation of asynchronous e-consult fee codes within a reasonable time horizon	• Government and DNS should evaluate the implementation of asynchronous e-consult fee codes within a reasonable time horizon to understand the overall service utilization, as well as the impact on referral volumes and wait times for specialist services to determine whether adjustments need to be made.
3. Consider clarifying the nomenclature of the modality	• Government should consider providing clarity on the nomenclature of the modality (e.g., e-advice) within the physician manual to avoid confusion with other synchronous and asynchronous virtual care modalities.

Concluding Remarks

Concluding remarks

- The analyses and recommendations laid out in this report set forward a clear vision and path forward to ensure Nova Scotia physicians are appropriately compensated for the virtual care they provide in a fee-for-service environment. This vision seeks to align all virtual care compensation decisions with broader health system strategic objectives, and to ensure compensation models are modality neutral, limit the administrative burden placed upon physicians, promote high-value care, provide a level of cost certainty to government, and are technically, politically, and financially feasible to implement and maintain.
- The majority of provinces across the country have been grappling with the same decisions being faced in Nova Scotia as it relates to synchronous virtual care. By taking a clear position on the inability to make long-term decisions in the absence of clear evidence or rationale, the province will be seen as a playing a leadership role nationally in this space. Further to this, as one of the only provinces not currently compensating physicians for provider to patient and provider to provider asynchronous care, the potential for positive impacts to patient access, amongst other factors, bode well for the future of our health system.
- As one of many inputs supporting Government's consultation around the future virtual care, the implementation of these recommendations will not be easy, and will take time, but will be necessary to build a sustainable future for virtual care in Nova Scotia.

Appendix A: Survey Results

Engagement of DNS Membership: Virtual Care Compensation Survey Highlights

The survey was opened for distribution by DNS beginning November 3, 2021, and closed on November 20, 2021.

329
Total survey respondents

48%
157 office-based family physicians

24%
78 surgical/ medical specialties

7% - Emergency Medicine
6% - Psychiatry
15% - All other specialties

59%
194 physicians based in Zone 4 - Central

16% - Western
12% - Eastern
9% - Northern
5% - IWK Health

47%
156 Fee-for-Service physicians (primary payment model)

Synchronous – Virtual Visits

- **75% of physicians** indicated one of their three preferred compensation options was parity for virtual and in-person services.
- **70% of physicians** feel that a virtual visit via telephone takes **more or the same amount of time** as in-person visits.
- Nearly a third of physicians **(30%) indicated they do not complete virtual visits via video**, and just over a quarter of physicians **(27%) 'do not know'** the time differential between their video and in-person visits.

Asynchronous – Secure Patient Messaging

- **94% of physicians** believe asynchronous secure messaging with patients should be compensated; however, there is no clear consensus on a preferred compensation model:
  - **39% of physicians** selected a flat fee per message/exchange as one of their top three.
  - **36% of physicians** selected a time-based approach as one of their top three.
  - **27% of physicians** selected a fixed stipend as one of their top three.

Asynchronous – E-Consults

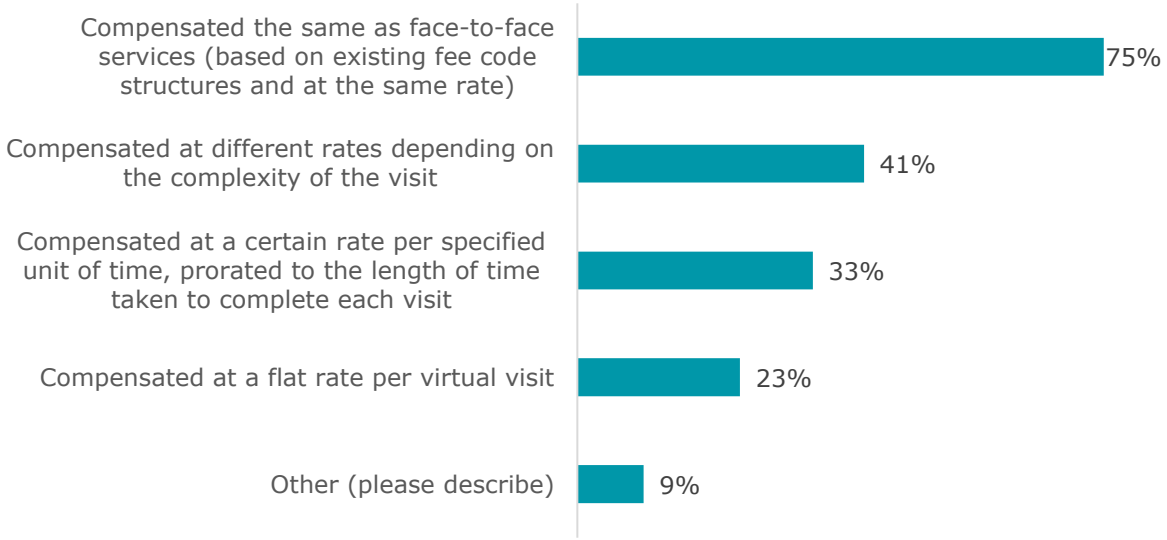
- **92% of physicians** believe the referring provider should be compensated for e-consults; **95% of physicians** believe the consulting physician should be compensated.
- **The majority of physicians (51%)** selected a flat fee for e-consult as one of the preferred option for compensating referring physicians; **only 16%** selected a type of stipend-based model (fixed/tiered).
- Similarly, **only 14% of physicians** selected a type of stipend-based model as a means to remunerate consulting physicians; there is no clear preference amongst physicians between flat fee and time-based approaches.

Engagement of DNS Membership: Virtual Care Compensation Survey Highlights

The majority of physicians believe synchronous virtual visits in a fee-for-service environment should be compensated the same as face-to-face services.

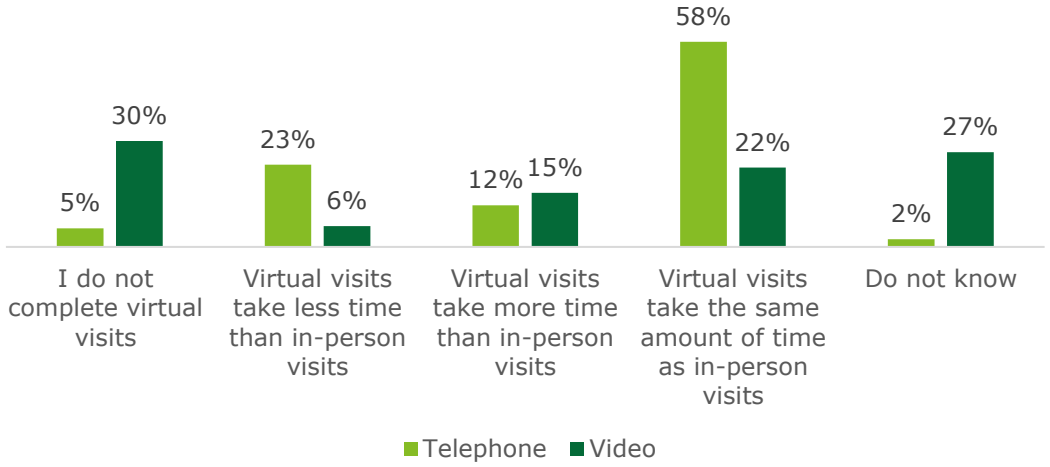
Synchronous Virtual Visits - all physicians

Physicians were asked to select up to three compensation models that believe would appropriately compensate physicians for their time spent providing virtual visits...



- **The majority of physicians (75%)** indicated one of their three preferred compensation options was parity for virtual and in-person services.

Duration of virtual visits – i.e., telephone or video vs. in-person visits



- **70% of physicians** feel that a virtual visit via telephone takes **more or the same amount of time** as in-person visits.
- Nearly a third of physicians **(30%) indicated they do not complete virtual visits via video**, and just over a quarter of physicians **(27%) 'do not know'** the time differential between their video and in-person visits.

Engagement of DNS Membership: Virtual Care Compensation Survey Highlights

However, there are diverging views with a small group of physicians discouraging broader adoption of virtual care.

Synchronous Virtual Visits - commentary from respondents who selected 'Other'

*Whatever model is chosen, I strongly believe that **compensation should not go down in any circumstance**. Some virtual visits (particularly for mental health reasons) are longer than office visits. In this instance, additional billing options to reflect the time it takes to adequately address most mental health issues would be appreciated.*

*[All virtual care modalities] together increase the access patients have with family docs and for family docs to meet the needs of their patients. **Remuneration needs to compensate for care provided to the patient**, that uses all mechanisms that enable secure and high quality care.*

*Virtual visits **typically take the same amount of time** as in-person visits, I would not support a reduced fee for virtual visits*

*I think fee should be such **that virtual care is discouraged!***

*Once the pandemic is over remunerate at **80% of regular in office AO25** visit. Until then remunerate at 100% dollars*

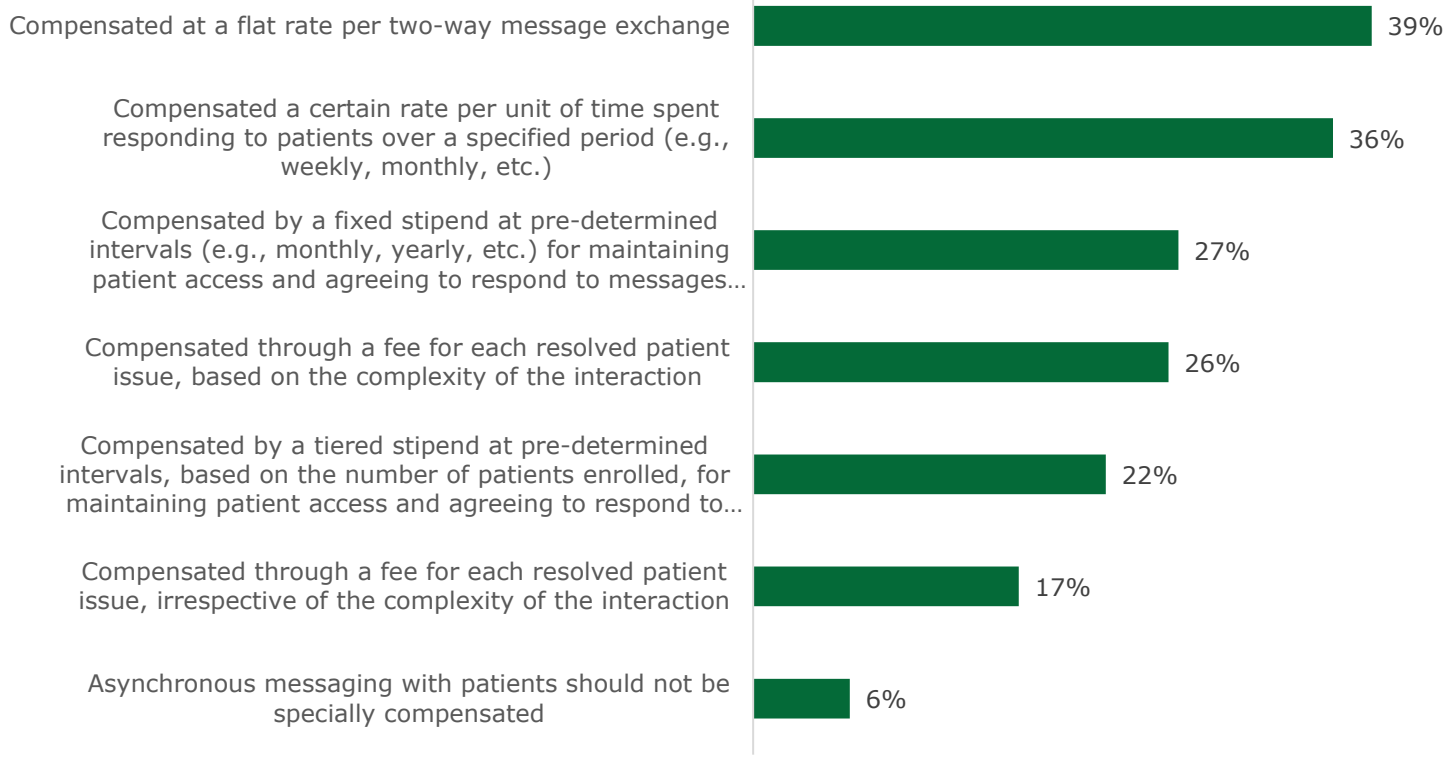
*The service is not the same. **Physical exam is not possible** and should not be compensated at the same rate.*

Engagement of DNS Membership: Virtual Care Compensation Survey Highlights

There is no clear consensus on a preferred compensation model for asynchronous patient messaging.

Secure Patient Messaging - all physicians

Physicians were asked to select up to three compensation models that believe would appropriately compensate physicians for their time spent messaging with patients as part of care delivery…

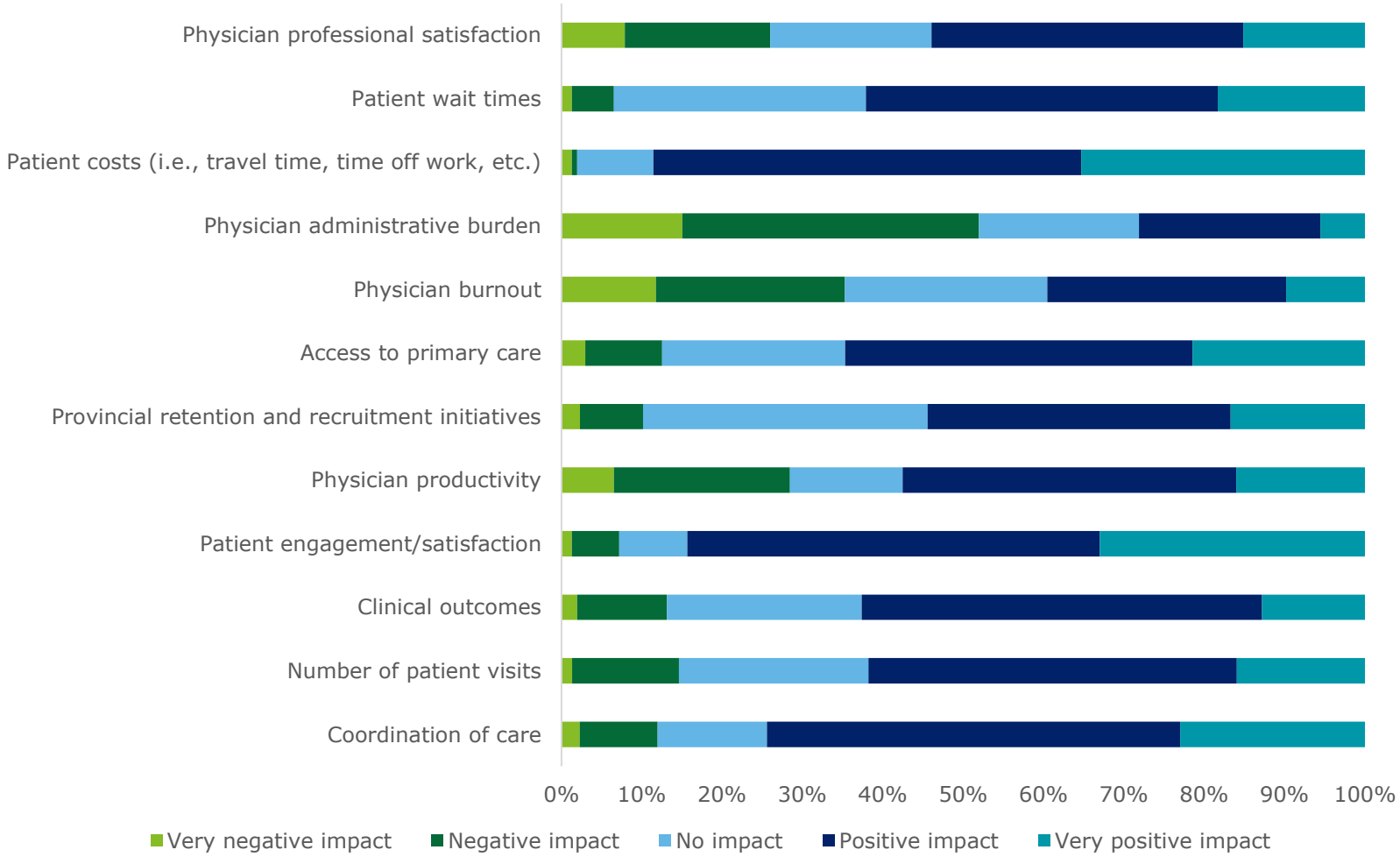


Observations

- **94% of physicians** believe asynchronous secure messaging with patients should be compensated
- However, there is no clear consensus on a preferred compensation model:
  - **39% of physicians** selected a flat fee per message/exchange as one of their top three
  - **36% of physicians** selected a time-based approach as one of their top three
  - **27% of physicians** selected a fixed stipend as one of their top three
  - **26% of physicians** selected a flat fee per patient issue (with complexity modifiers) as one of their top three

Engagement of DNS Membership: Virtual Care Compensation Survey Highlights

Degree of impact appropriately compensating physicians for secure patient messaging will have on...



Observations

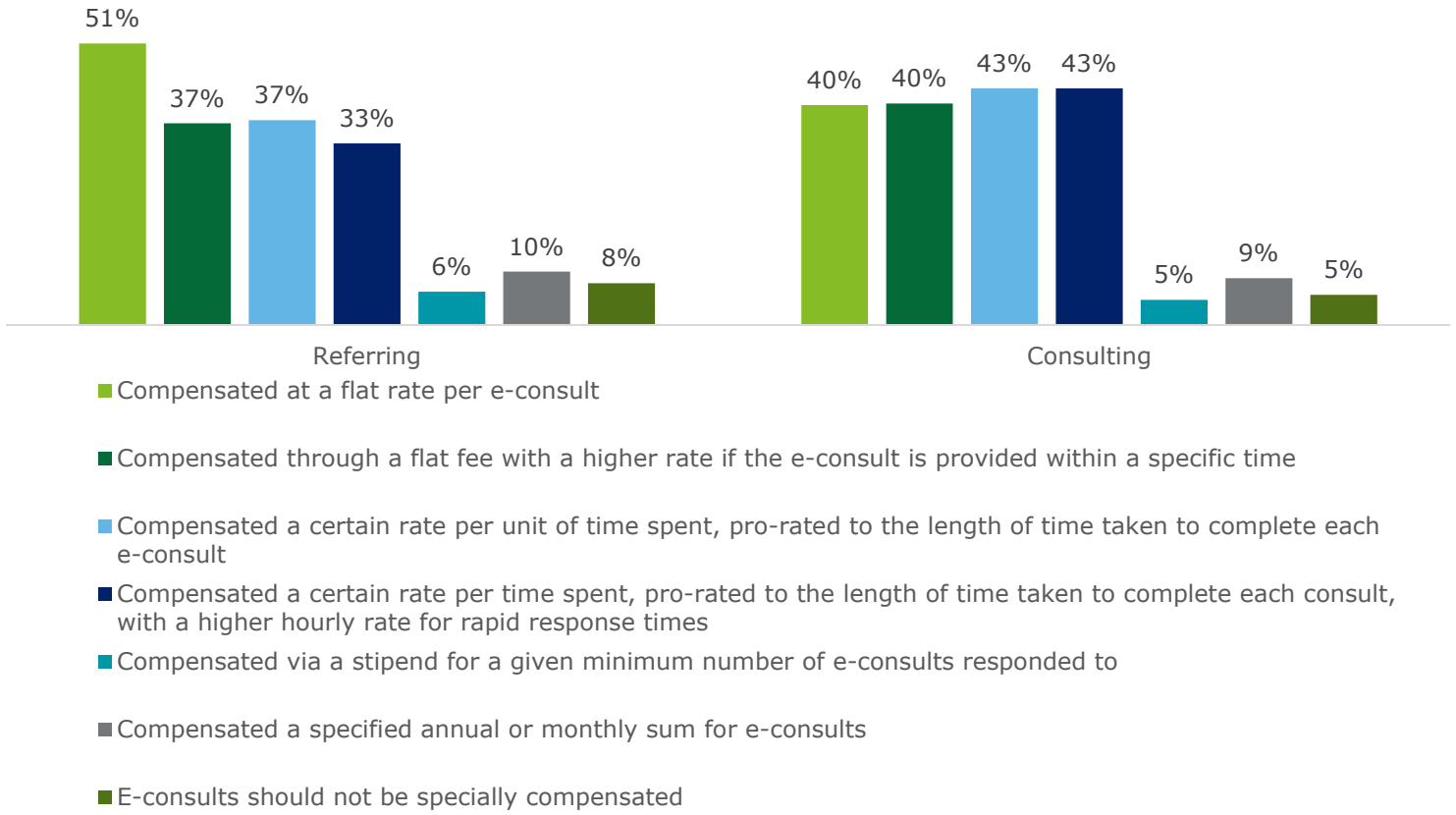
- Physicians overwhelmingly noted the positive or very positive impact compensating for secure patient messaging will have on the patient.
- **89% of physicians** indicated a positive or very positive impact to patient costs (i.e., travel time, time off work, etc.).
- **84% of physicians** indicated a positive or very positive impact to patient engagement/satisfaction.
- However**, the majority of physicians (52%)** indicated a negative or very negative impact to physician administrative burden.
- **Just over one third of physicians (37%)** indicate a negative or very negative impact to physician burnout.

Engagement of DNS Membership: Virtual Care Compensation Survey Highlights

Physicians prefer flat fee or time-based compensation options for both consulting/referring physicians completing e-consults.

E-Consults - all physicians

Physicians were asked to select up to three compensation models that believe would encourage broad adoption for referring and consulting physicians completing e-consults…

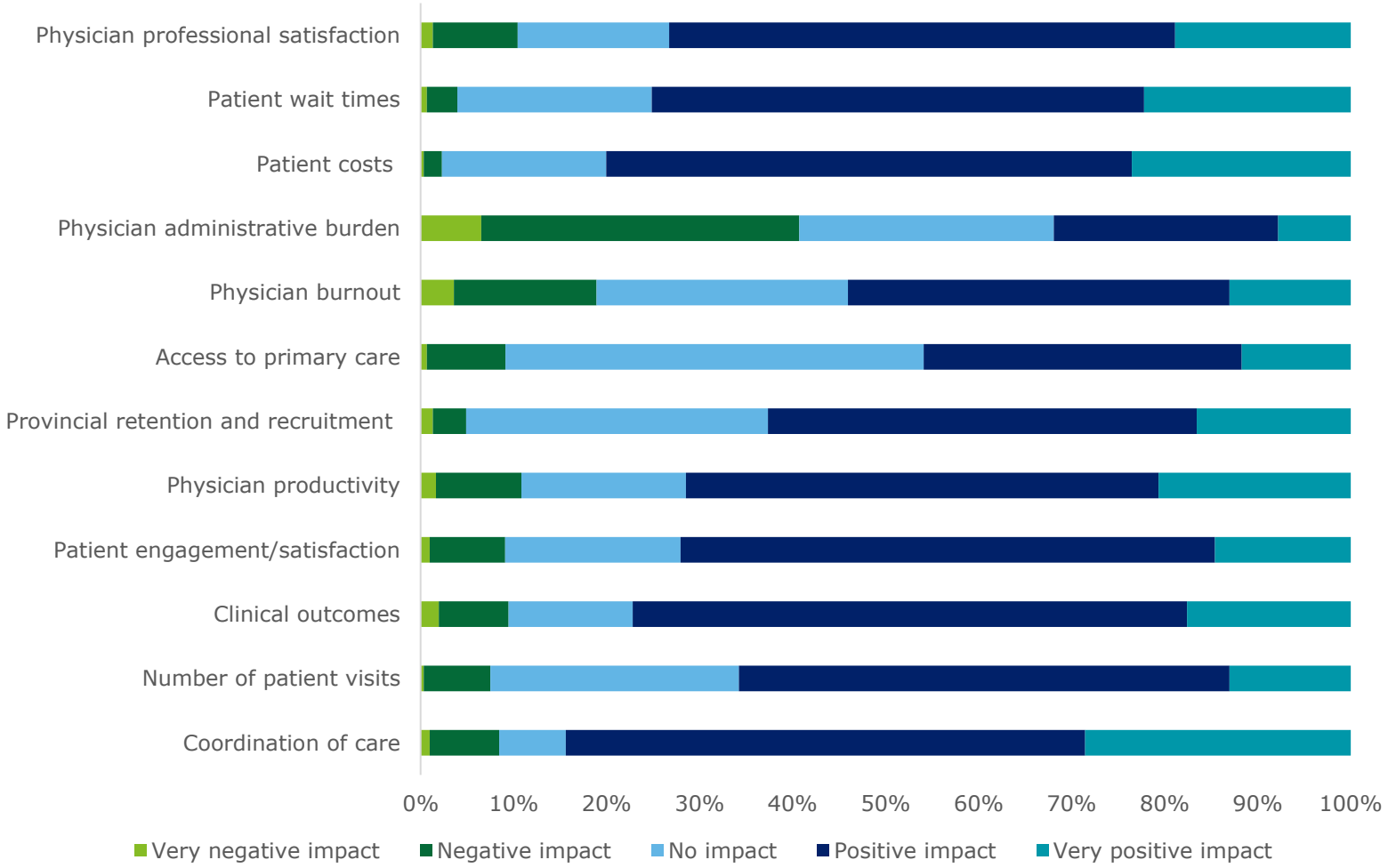


Observations

- **92% of physicians** believe the referring provider should be compensated for e-consults; **95% of physicians** believe the consulting physicians should be compensated.
- **The majority of physicians (51%)** selected a flat fee for e-consult as on of the preferred option for compensation referring physicians; **only 16%** selected a type of stipend-based model (fixed/tiered).
- Similarly, **only 14% of physicians** selected a type of stipend-based model as a means to renumerate consulting physicians; there is no clear preference amongst between physicians between flat fee and time-based approaches.

Engagement of DNS Membership: Virtual Care Compensation Survey Highlights

Degree of impact appropriately compensating physicians for e-consults will have on...



Observations

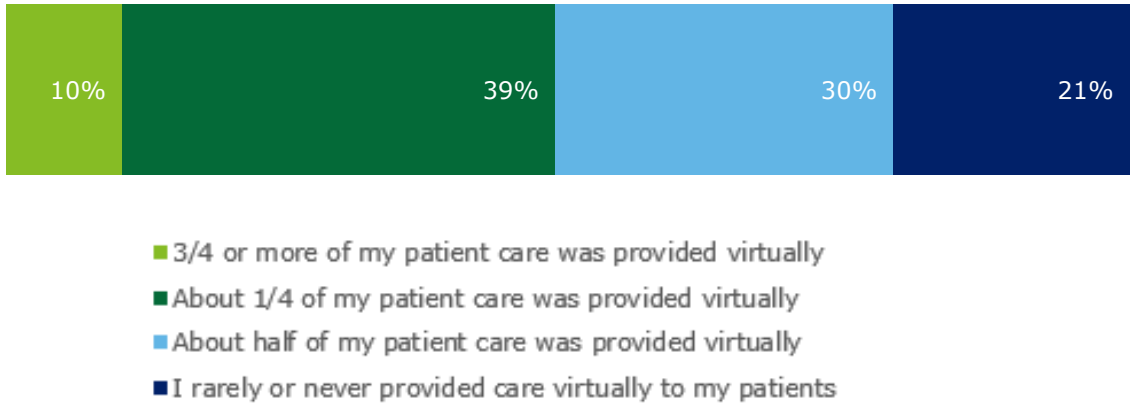
- The majority of physicians indicated that appropriately compensation would have a positive or very positive impact on most categories:
  - E.g. **86% of physicians** indicated a positive or very positive impact on coordination of care
  - E.g. **78% of physicians** indicated a positive or very positive impact on clinical outcomes
- Access to primary care, and physician administrative burden were the exceptions – where majority of physicians did not indicate a positive or very positive impact:
  - E.g. **45% of physicians** indicated e-consults have no impact on access to primary care
  - E.g. **41% of physicians** indicated e-consults will have a negative or very negative impact on physician administrative burden

Engagement of DNS Membership: Virtual Care Compensation Survey Highlights

Proportion of patient care provided virtually...

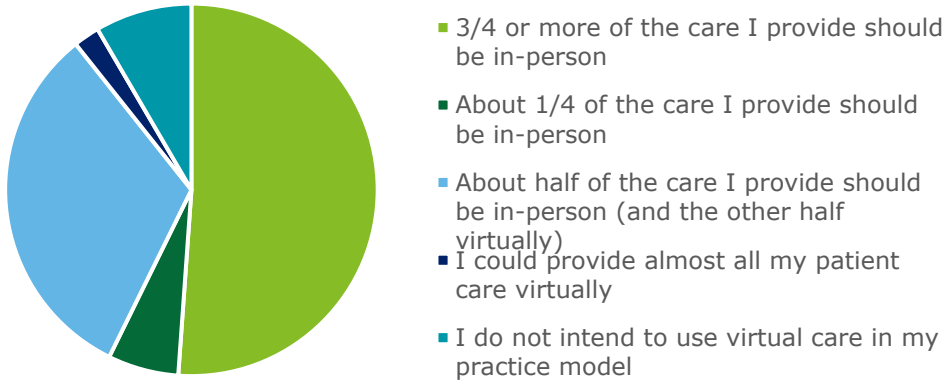
When the State of Emergency was declared in March 2020 and the temporary fee codes for virtual care were introduced (at the peak of lockdown):

Over July-October 2021:



The appropriate mix of virtual and in-person care moving forward...

Once the State of Emergency has ended and public health social distancing measures are no longer required, what do you feel will be the appropriate mix of virtual and in-person care in your practice model?



Observations

- At the peak of the pandemic, approximately 6 out of 10 physicians provided 75% or more of their patient care virtually; over the last six months only 1 out of 10 physicians provided this level of care virtually.
- Moving forward the majority of physicians (51%) feel that about 75% of the care they provide should be in-person.

Appendix B: Stakeholder Engagement

Stakeholders engaged

Target group	Consultations completed
Nova Scotia Health System Stakeholders	Dr. Kevin Orrell, Chief Executive Officer, Office of Health Care Professionals Recruitment
	Vimy Glass, Executive Director, Office of Health Care Professionals Recruitment, Government of Nova Scotia
	Vicki Elliot-Lopez, Senior Executive Director, Seniors and Long-Term Care
	Dr. Sam Hiscock, Chief Officer, Office of Mental Health and Addictions
	Andrew Nemirovsky, Chief Nursing Information Officer, Nova Scotia Health
	Dr. Douglas Sinclair, Vice President, Medicine, Quality & Safety, IWK
	Dr. Gus Grant, Registrar and CEO, College of Physicians and Surgeons of Nova Scotia
Other jurisdictions (i.e., PTMAs, Government)	John Maher, Chief of Negotiations & Physician Compensation, New Brunswick Medical Society
	Mark Ceaser, Director, Economics, Saskatchewan Medical Association
	Meric Osman, Team Lead Research & Data, Economics, Saskatchewan Medical Association
	Jim Aikman, Vice President, Economics, Advocacy and Negotiations, Doctors of BC
	Umer Sheraz, Manager, Strategic Projects, Government of Albera
Deloitte Subject Matter Experts	Mark Bethke, Managing Director, United States
	Dr. Rohan Hammett, Partner, Australia
	Karen Taylor, Director, Centre for Health Solutions, United Kingdom
Nova Scotia Physicians	DNS e-Health Committee
	DNS Section Forum
	~60 participants virtual care compensation physician webinar
	329 physician virtual care compensation survey respondents

Steering Committee Composition

The following individuals made up the Steering Committee for this engagement:

Department of Health and Wellness	Angela Purcell, Senior Executive Director, Physician Services
Department of Health and Wellness	Azam Muhammad, Project Executive
Doctors Nova Scotia	Stewart Gray, Senior e-Health Strategist
Doctors Nova Scotia	Alana Patterson, Director, Physician Compensation and Practice Support

Appendix C: Jurisdictional Scan Summary

Jurisdictional Scan

Jurisdiction	Synchronous – Virtual Visits	Asynchronous – Secure Patient Messaging	Asynchronous – E-Consults
British Columbia	• Telehealth fees to be used when the service is rendered over the telephone. • Telehealth fees to be claimed for consultations, office visits, and non-procedural interventions where there is currently no telehealth fee. These may be claimed under the "face to face" fee with a claim note record that the service was provided via video technology or telephone and is payable by MSP.	• Two-way communication via email/text for family physicians are compensated at $7.00 for family physicians and $10.10 for specialists • Payable to a maximum of 200 services per physician per calendar year	• Referring physicians are not compensated for e-Consults, and specialists are compensated using a flat fee model ($10.10).
Alberta	• The Alberta government announced new codes introduced during the pandemic (without limitations) will remain in the Schedule of Medical Benefits permanently. • There are 7 fee codes (without limitation) which can be billed at an equal rate to the in-person equivalent (varying by specialty); additional premiums such as age or complexity modifiers will not apply	• As part of the permanent fee codes introduced - Physician to patient secure electronic communication was included with limitation: Maximum 1 per patient per week to a maximum 14 per week per physician.	• Fee codes in place for both referring and consulting physicians – referring physicians are billed just under 50% of the consulting physician rate – no fee modifiers are in place for either code.
Saskatchewan	• Introduced pilot virtual fee codes costed using a rate of 90% of the in-person fee. • This rate was settled upon through the throes of government negotiation rather than through robust data analysis to support the differential. • The medical association and government will revisit this approach in March 2022.	• Not compensated for secure messaging currently.	• Major and minor consult fees are offered through telephone consultations: • *Leveraging Immediate Non-urgent Knowledge*, or LINK, is a telephone consultation service to give primary care providers and their patients rapid access to specialists to discuss less serious patient conditions.
Ontario	• In response to the pandemic, temporary virtual care codes were introduced on March 14, 2020 as part of the OHIP schedule for an initial period of 12 months. • These allow all physicians to bill for virtual care through video and telephone. Telephone or video visits are generally remunerated on par with face-to-face visits, but do not include payment for additional complexity modifiers.	• Physicians in the EAPC initiative remunerated on a tiered-FFS basis for each completed visit or interaction as opposed to a per message fee. • Minor assessments were compensated at $15.00 ($2.25 capitation) and intermediate assessments were compensated at $21.70 ($3.25 capitation).	• In an effort to address excessive specialist wait times, Ontario introduced the Champlain BASE eConsult Service in 2010 to allow primary care providers to connect with specialists and send questions concerning patient care. • Specialist physicians are compensated through a pro-rated hourly fee of $200/hour for the length of time spent answering a case, while referring family physicians are remunerated through a flat fee of $16.
New Brunswick	• Virtual codes in place to enable virtual visits to be build at an equivalent rate. Virtual walk-in clinic visits can be billed at the same rate as a face-to-face walk-in clinic visit. • The location on the claim is used to denote whether the visit took place in-person or virtually. • These codes have been extended until March 31, 2022.	• Physicians practicing under the Family Medicine New Brunswick capitation model are able to bill for some email communications with patients. • They also have the ability to delegate email communication to a family practice nurse.	• New Brunswick has e-consults in place – the program provides compensation to specialist physicians only.

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