ACCESS to PRIMARY HEALTHCARE in NEW BRUNSWICK

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Executive Summary

Access to primary healthcare services in New Brunswick is in crisis. The number of people in our province without a family physician is a serious problem. The list is growing longer each year. It is time for our provincial government, the New Brunswick Medical Society, and individual physicians to address the issue and to provide solutions. If our province is to reach its economic potential, New Brunswick must improve access to primary healthcare. We need a system whereby all of our residents, including immigrants and people moving here for employment, will have a family physician. We outline how government, the two regional health authorities, educators of primary healthcare providers, and professional organizations of providers, can impact access to primary healthcare.

The pivotal decisions needed to decrease the number of patients without a family physician will be made in family physicians' offices. We propose that advanced scheduling techniques and collaborative staffing arrangements will encourage larger and access-friendly practices. We highly recommend team-based care in which many practices will employ a family practice nurse (with funding support), and in which some practices will establish a working relationship with a nurse practitioner. It is the addition of the nurse that is the decisive factor which will promote an increased practice size without compromising work-life balance.

After hours care will be accomplished by evening and weekend family physician office sessions, by some after hours clinics, and by urgent care centres strategically located near crowded emergency departments.

We are witnessing a transformation to inpatient hospital care. The hospitalist is playing an increasingly greater role. Inpatient care has been a vital component of the family doctor-patient relationship. Continuity of care and maintenance of clinical skills are enhanced by caring for sick patients in the hospital setting. We must maintain a role for the family physician in hospital care.

Despite intense competition, an aggressive physician recruitment and retention effort is essential. We recommend a strategy with established physician to new physician communication, aided by prompt coordinator services, and designed to meet the needs of both the new physician and the community.

We recognize the challenges facing the nursing profession. Along with a serious nursing shortage, the current demands in the workplace are so stressful that burnout and premature retirement are commonly encountered. As physicians, we support urgent action to educate more nurses and to improve working conditions.

Family physicians recognize that the doctor-patient relationship is the cornerstone of good primary healthcare. This relationship develops over time in multiple situations, such as the office, the patient's home, nursing homes, primary obstetrical care, extra mural hospital care, and inpatient hospital care. There is no patient so ill that their family physician cannot contribute to their care.

With the privilege of being a physician, there is a responsibility to make access to primary healthcare a priority.

Introduction

We are four retired family physicians. Individually we have been watching as access to healthcare has become an increasingly challenging issue for the people of New Brunswick. We decided to talk about our concerns and to help find solutions. We chose to focus on access to primary healthcare. We base our ideas and suggestions on our various primary care experiences, including clinical practice, administration, teaching, and on several interviews with people who have keen interest and experience in primary care. This report summarizes our deliberations.

Thousands in our province suffer daily because they do not have appropriate access to primary healthcare services. Practices of established family physicians who are nearing retirement may be large, and often require more than one replacement physician. Many family physicians want smaller practices to support their work-life balance. These realities and other factors have resulted in a nationwide shortage of family physicians, causing strong competition among the provinces and territories to fill vacancies.

Not having a family physician, many New Brunswick citizens miss out on timely access to comprehensive and continuing care. Take, for example, the case of Ron and Anna. They are 82 and 80, and they have had one family physician for 30 years. Their doctor is retiring and does not have a replacement. Ron and Anna still manage to live independently in a senior's apartment. Ron has Parkinson's disease and early dementia. Anna is an insulin dependent diabetic and has high blood pressure. They are on several medications. Their chronic health problems cannot be managed adequately by trips to the after hours clinic or to the emergency department. Without a family physician they do not have reasonable access to the Canadian healthcare system. Their conditions will continue to deteriorate until an emergent problem requires that one of them is admitted to the hospital, while the other is admitted to long term care.

This is not an isolated case. New Brunswick has many citizens like Ron and Anna, with chronic diseases, on multiple medications, and needing access to a family physician. Ron and Anna's case illustrates the two major indications of a problem with access to primary healthcare:

1) More than 40,000 New Brunswick residents do not have a family physician, including more than 13,000 residents of health zone 3 (the Fredericton region).
2) There are unacceptably long wait times for various healthcare services, including emergency department care and elective surgeries.

Addressing such problems requires multiple solutions such as:

1) Recruit more family physicians.
2) Reorganize some office practices to add more patients.
3) Reorganize office scheduling to permit timely access for acute episodic care visits during office hours, and during evening and weekend office sessions.
4) Reorganize office staffing by attracting non-physician providers (family practice nurses, nurse practitioners) to join family physicians in team-based collaborative primary care.

It will take the four approaches together to successfully address the access problem. Alone, none of the approaches is sufficient. The problem will be solved gradually over several years. In addition, therefore, we must create some short-term interim solutions to alleviate the unacceptable access problems for patients without a family physician.

Following are some suggestions that, over the long term, should improve access to primary healthcare. These ideas are directed towards providers of primary care, their educators, and their professional organizations. While some of the suggestions are not new, we include them for completeness.

Providers of Primary Care

A. Family Physicians

Our goal is to encourage the establishment of larger and access-friendly practices, while respecting work-life balance.

Several varieties of physicians provide primary care. There are family physicians, emergency room physicians, hospitalists, and others who work in areas of special interest. Only family physicians conduct regular office practices**.** This reality is important for family physician resource planning. All family physicians should know the number of patients (panel size) in their practice. For many years, New Brunswick citizens have averaged just over 3 office visits per year.

The trend in many jurisdictions is to recommend a practice size at entry into practice. The College of Family Physicians of Canada suggests a start up panel size of 1000 patients. After 2 years a further 200 patients should be added. By employing a family practice nurse (supported by government funding), 300 more patients could be added. Some practices might also add a nurse practitioner,

making a 2000 patient practice a possibility. Each practice will develop its own unique staffing arrangement.

For several reasons, a new family physician might want a smaller practice. This recruit should be welcomed by colleagues and by the community. A mutually agreed upon part-time arrangement should be negotiated.

After hours care is an essential component of an access-friendly practice. Each member of a family physician group should conduct some scheduled evening and weekend office sessions.

With an increasing role for hospitalists, family physicians are withdrawing from hospital care. Inpatient care is time consuming, but it is important in maintaining clinical skills, in achieving continuity of care, and it adds value to the doctor-patient relationship. Further, by not spending time in the hospital setting, family doctors are decreasing their in-person contact with hospital consultants. Hospital care by family physicians should be encouraged and remunerated at the same level as for hospitalists.

Another component of an access-friendly practice is use of the advanced scheduling techniques that are encouraged elsewhere in Canada. Same day/next day appointments are combined with traditional regularly scheduled appointments in proportions that suit the practice.

The electronic medical record (EMR) is a vital component of clinical care. With government leadership, a bilingual, standardized, province-wide EMR system must be accomplished.

Influenced by COVID-19, virtual care has become a component of medical practice. It has been well received by both physicians and the public. It has improved access to healthcare, but it does not improve quality of care. Face-to-face contact is essential to provide good patient care. Virtual care has a role within a continuity of care framework involving patients known to the provider.

In New Brunswick, family physicians have been introduced to two team-based collaborative care approaches.

1) The Regional Health Authorities have developed a variety of community health centres, some rural, some urban. Physicians can be salaried and see themselves as employees.
2) In 2018, the New Brunswick Medical Society introduced Family Medicine New Brunswick (FMNB) with substantial government support. In this collaborative care model, physicians are self-employed and are reimbursed by a blended remuneration system.

We are concerned about the slow growth of team-based care in New Brunswick, a situation that deserves prompt attention. Team-based practices are larger in size and improve access to primary healthcare.

Team-based primary care will be the favoured practice style of the future. Many efficiencies accrue within such collaborative care practices. Team members include family physicians, family practice nurses, and support staff. Some teams will add a nurse practitioner. We suggest that other allied health professionals not be included initially, until a specific need is demonstrated. As noted above, an attractive feature of team-based care is that the practice size can be larger than practices without a nurse. Team-based practices guard against a future with multiple silos of independent, competing, primary care providers. Fragmented care must be avoided.

Some family physicians prefer the traditional independent fee for service practice model. They have been the backbone of the primary care delivery system for many years. For good reason, the choice for family physicians to practice independently, with group sign out arrangements, must be maintained.

B. Rural Providers

Many rural communities do not have a family physician and recruiting a rural family physician is a challenge. Without a local doctor, travel for non-urgent care can become an obstacle. For urgent/emergent care, a consistent and dependable paramedic/ambulance service is essential. It is paramount that the provincial government maintains a well-run rural ambulance service.

Some rural communities have been successful in attracting one or more family physicians. Team-based community health centres have worked well in some rural areas. The health zones in which they are located, and the nearest regional hospital should develop a special relationship with these rural physicians, ensuring timely access when their patients require lab services, referrals, and hospital care. Additionally, urban family practices should plan openings for rural patients as their patient panel is being established or expanded.

C. The Family Practice Nurse

The family practice nurse is an RN working with a family physician in an office setting. Family practices that employ family practice nurses have demonstrated improved access to care, improved patient and physician satisfaction, improved quality of care, and improved cost effectiveness. Family practice nurses provide

a broad range of clinical services including phone and on-site triage, patient education, follow up care, and various therapeutic interventions, such as well baby care and immunizations. Some also develop areas of special interest.

We acknowledge that at this time, a major shortage of nurses in our province significantly limits the availability of RNs who might wish to work as family practice nurses.

We suggest that the family practice nurse in the RHA team-based practices be hired using an application/interview method. A dedicated family practice nurse should be chosen by the care team, and not appointed by the RHA.

The provincial government should expand its programme whereby family practice nurses can bill for selected clinical services. By doing so, the government will fund a large portion of the nurse's salary, encouraging more family physicians to hire family practice nurses.

The overall nursing shortage in our province is of paramount importance. This must have immediate attention.

D. Nurse Practitioners

Nurse practitioners are RNs who have additional education and nursing experience which enables them to diagnose and treat illnesses, order and interpret tests, prescribe medications, and perform certain medical procedures. In Canada, a nurse practitioner's formal education is comprised of the RN degree plus two years of Masters level studies, which includes a minimum of 700 hours of clinical training. Each province and territory has nurse practitioner legislation that regulates the scope of their clinical activities.

Nurse practitioners work effectively within a team-based setting. A family physician and a nurse practitioner can serve each other's patients, and, when necessary, make key clinical decisions together. After considering the role of nurse practitioners, our suggestion is that they are best positioned, not to work independently, but to establish a working relationship with a family physician to provide a caliber of primary care services better than either could provide alone.

Educators of Providers

A. Medical Schools

Medical schools and family medicine residency programmes can help with access to primary healthcare by graduating more family physicians and by educating them about the access issues so that they will establish access-friendly practices.

Medical schools are educating students who become more interested in the specialties than in family medicine. We must enhance our efforts to make family medicine more attractive to medical students. Medical schools should use family physicians as instructors, preceptors, and tutors in the case-based learning modules in their first and second years.

Family medicine residency programmes should develop a series of access-inspired seminar topics. Suggestions are: advanced scheduling techniques, team-based care, the basics of the electronic medical records, a prudent approach to virtual care, and practice styles. Encouraging new family physicians to establish access-friendly practices is imperative.

B. Faculties of Nursing

Addressing the overall nursing shortage is critical. A robust approach with leadership by government and the nursing profession is urgently needed. Nursing faculties can contribute to the access issue by helping to elevate the family practice nurse to a more prominent and visible place in the primary care delivery system. We encourage the development of a comprehensive undergraduate elective that would introduce interested RN students to family practice nursing. In Nurse Practitioner programmes, we support the development of seminars on strategies to prepare nurse practitioners for working in collaboration with family physicians, using both nurse practitioner and family physician tutors.

Professional Organizations

A. Nurses Association of New Brunswick (NANB)

The NANB acts as the licensing body for practicing nurses and ensures that professional standards are met. The NANB can contribute to the access issue by taking steps to increase the awareness of the family practice nurse. Following

Nova Scotia's lead, we suggest the creation of a New Brunswick chapter of the Canadian Family Practice Nurse Association (CFPNA), providing family practice nurses with pertinent lifelong learning opportunities. Home-grown workshops, organized by the NANB and nursing faculties would be a valuable educational tool.

B. New Brunswick Medical Society (NBMS)

The NBMS is the voice of the medical profession in New Brunswick. Its importance as the liaison between government and physicians leads to valuable planning, negotiation, and implementation activities.

With strong government support, the NBMS recently introduced "Family Medicine New Brunswick" (FMNB). Several groups of team-based collaborative care practices have been established. Attractive features were incorporated including: blended remuneration for physicians, billing for selected nursing services, advanced scheduling techniques, and after hours care. We suggest that the NBMS consider adding an FMNB family physician as a consultant to the FMNB management team.

In the recently released "Tentative Physician Services Master Agreement", a welcome new initiative was introduced. The New Brunswick Primary Care Network, developed by the NBMS and the Department of Health, will deliver primary healthcare services to every resident of New Brunswick who does not have a primary care provider. The goal is to eliminate the "Patient Connect" list of people seeking a family physician. As we await the details, we see this undertaking as a positive short-term approach to solving the access to primary healthcare dilemma. It dovetails nicely with our report, which tackles the access problem from a long-term perspective.

C. College of Family Physicians of Canada (CFPC)

Beginning in 1954 the CFPC became the voice of family medicine in Canada. Its main function is setting standards for education of the family physician during residency programmes. Family medicine residents depend upon the CFPC residency experience for two important outcomes: a toolbox full of pertinent clinical skills and a clear understanding of what is expected of them at entry into practice.

The CFPC should raise national awareness by declaring “a focus on access to primary healthcare”. This declaration would include initiatives such as regularly publishing scholarly articles on access in their monthly publication.

All family medicine residents should make themselves familiar with “the Patient’s Medical Home”, a well-organized programme of the CFPC, which, among other purposes, serves as a guide to establishing an efficient access-friendly family practice.

Other Key Stakeholders

A. Government of New Brunswick

New Brunswick citizens have entrusted government with a mandate to provide clear and focused leadership in publicly funded primary healthcare, to be delivered by a family physician or a collaborative care team.

Government contributes to access to primary healthcare services through two important activities: planning, with input from appropriate stakeholders, and funding.

Issues requiring immediate government leadership and action include:

1) Auditing the number of family physicians conducting primary office care as compared to those working in other settings
2) Addressing the nursing shortage
3) Developing Urgent Care Centres associated with all 8 regional hospitals
4) Delivering a provincial bilingual standardized electronic medical record system
5) Providing funding assistance for family practice nurses

B. Regional Health Authorities (RHAs)

The role of New Brunswick’s two RHAs is to manage and deliver a variety of healthcare activities, including hospital services, community health centres, extramural services, and mental health programmes.

The two RHAs play an important coordinating role in physician recruitment. The goal of the recruitment process should be to have physicians recruiting physicians, aided by a prompt and courteous coordinator service.

RHAs are also positioned to play a role in after hours care. Recent indications are that after hours clinics are on the decline, except in the Moncton area. Urgent care centres, managed by the RHAs, could take their place and would reduce demand on crowded emergency departments. Urgent care centres are larger, more complex operations than after hours clinics. With dedicated medical and nursing staff, they should be established at all regional hospitals. Close proximity and close organizational relationships between urgent care centres and emergency departments is necessary. In the future, after hours care should be accomplished by a combination of evening and weekend family physician office sessions, by a few after hours clinics, and by strategically located urgent care centres.

Recruitment and Retention of Family Physicians

Vigorous competition exists among the provinces and territories for hiring family physicians. Our province has a recruitment advantage when the doctor grew up in New Brunswick, the doctor studied and trained in New Brunswick, and/or the doctor married a New Brunswicker. We should focus New Brunswick's recruiting efforts on these individuals.

Ongoing communication with medical students who grew up in New Brunswick and with family medicine residents training in New Brunswick is very important. Our goal should be to make these students and residents feel respected and appreciated. This undertaking is time consuming, and requires organization, coordination, and teamwork, with meaningful physician input.

An effective physician recruitment effort requires a coordinator, designated physician recruiters, and an attention-grabbing job description. A provincial master plan, with a detailed listing of all vacant family practice opportunities, should be compiled and updated regularly.

Site visits by serious enquirers and their spouses should be arranged by the coordinator and funded by the government. Conversations with community representatives should be arranged with the new physician's input. Efforts by the recruiting team to accommodate the needs of the new physician's family are both worthwhile and appreciated.

We encourage our government to craft New Brunswick's approach to recruitment incentives by considering what we can afford, what other provinces are doing, and what recent recruits are saying. We appreciate the efforts of the NB Medical Education Foundation as they raise funds and grant substantial scholarships to medical students in return for a return of service agreement.

Retention is as important as recruitment. Keeping family physicians in practice longer, winding down with less responsibility and a reduced time commitment, can be an attractive option. Flexible arrangements include practice sharing with a new physician. To assist with future planning, we suggest that physicians give a three year notification of retirement intention.

Finally, we emphasize once again, that overall recruitment activity should be guided by a strategy of physicians recruiting physicians, with appropriate administrative support.

Final Thoughts

As documented in this report, we have serious concerns about the crisis in access to primary care in New Brunswick. Our final thoughts focus on the following issues:

There is a nationwide shortage of family physicians. There is trend for family physicians to have a smaller practice size than in the past. Therefore, New Brunswick must develop a coordinated and aggressive recruitment plan to attract family doctors to this province.

For recruitment and planning purposes, there needs to be an audit of the number of family physicians providing primary office care in New Brunswick.

Family physicians now wish to work primarily in group practices. In this light, the Family Medicine New Brunswick Program needs to be promoted. The addition of a family practice nurse or a nurse practitioner creates a truly collaborative healthcare team, increasing the access to primary care.

The overall shortage of nurses is of great concern. This diminishes the pool of RNs who might consider a career as a family practice nurse.

On a temporary basis the New Brunswick Primary Care Network will provide a good service to New Brunswick residents without a family doctor. However, long-term commitment by individual physicians is not guaranteed. Furthermore, there is a concern that their involvement in the network may reduce their time commitment to their current primary care duties.

Urgent Care Centres, with dedicated medical and nursing staff, need to be developed in association with all New Brunswick Regional Hospitals to reduce

the demand on our emergency departments and to improve access to primary care.

The doctor/patient relationship is the cornerstone of good primary health care. Continuity of care strengthens this bond. While acknowledging the growing trend for hospitalist care, we suggest that the role of the family doctor in inpatient care should be maintained.

The prime consideration of all health matters should be the needs of the patient. Medical systems, administrative matters, and politics should not overshadow the guiding principle of doing the best thing for the patient.

The 2002 New Brunswick Charter of Rights states that all residents have the right to access to care in one's local area, continuity of care, and services from a family doctor or collaborative practice team.

In order to solve the current crisis in primary care, the government of New Brunswick must provide strong and focussed leadership.