Physician Remuneration for Remote Consults: An Overview of Approaches across Canada

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Abstract

While lengthy waits for medical specialists remains a persistent problem across Canada, remote consult presents a strategy to address this issue. Connecting primary healthcare providers to specialists via electronic (eConsult) or telephone consult enables care providers to deliver appropriate, speciality-informed care for their patients in the primary care setting, reducing the time spent waiting for specialists and potentially preventing unnecessary referrals to specialty care. These remote consult models are the focus of a new pan-Canadian quality improvement collaborative delivered by the Canadian Foundation for Healthcare Improvement in partnership with Canada Health Infoway, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. Successful implementation of remote consult services requires alignment of remuneration for physicians. This article presents an overview of compensation arrangements across Canada for remote (telephone or electronic) and select in-person consults. It also shares key messages for payers and providers to inform future direction in this area.

Introduction

Canada takes home last place for timely access to specialists – in international comparisons, it ranked worst of 11 countries (Osborn et al. 2016). In fact, 56% of Canadians reported waiting more than a month to see a specialist, compared to the 36% international average (Osborn et al. 2016). Among the strategies to address waits are remote consults – programs such as Champlain BASE™ eConsult Service (BASE™; http://www.champlainbaseeconsult.com) and Rapid Access to Consultative Expertise (RACE™; http://www.raceconnect.ca/) consult (Champlain BASE eConsult 2017; RACE 2017). These programs enable primary healthcare providers to connect directly with specialty services, facilitating specialist-informed patient care in the primary care setting (Keely et al. 2013; Kramer 2013). Spreading the implementation of remote consult is the aim of a new pan-Canadian quality improvement collaborative, *Connected Medicine: Enhancing Primary Care Access to Specialist Consult*, delivered by the Canadian Foundation for Healthcare Improvement (CFHI) in partnership with Canada Health Infoway, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada (CFHI 2017).

Among the commonly cited barriers to initiating and spreading remote consult solutions are physician remuneration, privacy concerns and cross-jurisdictional regulation issues, all of which have been explored at length (Liddy et al. 2015, 2016). Physician remuneration is repeatedly raised as a significant barrier to implementing remote consult in some regions in Canada. This article provides an overview of the physician remuneration arrangements across the country for delivering remote consult. Understanding these arrangements, and developing strategies to address the challenges, may further support a move to scale remote consult across Canada. The information shared herein may also provide guidance to jurisdictions to inform future direction in establishing their own remuneration arrangements for delivering remote consult.

Methods, Limitations and Results

A consultation is when a healthcare provider (the referring provider) requests the opinion of a physician competent to provide advice in this field (the consultant). This request is made after the referring provider has carried out an appropriate examination of the patient, and with consideration of the complexity, obscurity, urgency or severity of the case. For both in-person and remote consults, the consultant is obliged to perform an assessment, review the pertinent patient medical information and submit findings and recommendations to the referring provider. The main difference between the two scenarios – in-person versus remote – relates to the assessment: in a remote consult, the consultant does not physically see the patient and, therefore, must ensure that the information received from the referring healthcare provider is adequate to render an opinion.

The data presented (Table 1) were compiled in June 2016 from provincial medical associations (key informants), provincial and

territorial physician fee schedules (online) and the Champlain BASE™ eConsult Service. For comparison purposes, we present remote versus in-person consult fees. The fees pertain to fee-for-service encounters. All consultants can bill for in-person consultations, but the mechanism for the referring and the consultant physicians to bill for remote consults varies across jurisdictions. Where remote consults are billable, certain jurisdictions permit consultants to bill for that service only when the services are initiated by select healthcare providers, in addition to physicians (refer to provincial and territorial fee schedules for further information). Because fees for in-person consults can vary by specialty, each range presented denotes the lowest and highest basic consult fee for the respective jurisdiction.

Overall, Table 1 presents summary information only; for more comprehensive and timely information, please refer to the original sources (refer to Appendix 1; available at: http://www.longwoods.com/content/25294). This analysis excludes activities that are billable only when the patient is present (for example, telemedicine services) and specialist-patient follow-up telecommunications.

TABLE 1.
Physician fee-for-service billing amounts for telephone, electronic and in-person consultations

Province/ territory	Telephone		Electronic		In-person consultation
	Referring physician	Consultant	Referring physician	Consultant	Consultant
NU	N/A – physicians are paid sessional rates or via term contracts[1]				
NT	N/A	$17.47[2a] or $29.13[2b]	N/A – physicians are salaried		
YT	No	$37.50[3a] or $41.60[3b]	No	$36.80[3c] or $41.60[3b]	$101.60–$468.00
BC	$40.00[4a]	$15.14,[4b] $15.16,[4c] $40.00[4d] or $60.00[4e]	No	$10.10	$64.00–$233.91
AB	$32.90–$45.21 (dependent on time of day)[5a]	$77.35–$135.13,[5a] $17.23–$27.83[5b] (dependent on time of day), $17.23[5c]	$32.43	$76.27	$77.25–$241.82
SK	No	$50.50 (major), $20.40 (minor)[6a] or 12.50[6b]	No	$12.50[6b] or $20.40[6c]	$61.20–$229.40
MB	$15.35[7a]	$15.35,[7b] $47.50,[7c] or $60.00[7d]	No	$15.35[7b]	$74.05–$252.60
ON	$31.35	$40.45	$16.00	$20.50[8a] or $45.72[8b]	$65.90–$199.40[8c]
QC	$26.00[9a]	$17.00,[9b] $35.00[9c] or $75.00[9d]	No	No	$74.05–$404.00
NB	No	No	No	No	$100.00–$200.00
NS	$27.83[10]	$60.50[10]	No	No	$150.04[10]
PE	No	$45.00[11]	No	No	$80.00–$205.00
NL	No	No	No	$50.00[12]	$50.51–$250.00

[1]No information available regarding the provision of specialist services.

[2]Physicians are salaried. Consultants from outside NT can bill NT as follows: [2a]Teleconference from physician, nurse practitioner (NP) or midwife; [2b]Review of imaging by a non-radiologist.

[3a]Telephone calls from community NPs to physicians providing scheduled emergency coverage in the hospital. [3b]Remote communication from physician. [3c]Remote communication from non-physician.

[4a]Billable only by a referring physician who is a general practitioner (GP). [4b]Calls initiated by a Community Health Representative from a First Nation Community. [4c]Remote communication from non-physician. [4d]GPs who are the consulting physician for a call from an NP. [4e]GPs with specialty training.

[5a]Telecommunication between physicians. [5b]Telecommunication initiated by select types of non-physicians. [5c]Telecommunication initiated by a pharmacist.

[6a]In SK, the consultant may bill for a major or minor telephone assessment – for a major assessment, the consultant must provide a written submission of the consultant's opinion and recommendations to the referring physician; for a minor assessment, the consultant may respond by telephone, fax or e-mail. Remote telephone calls from nurses are billed at the minor rate. [6b]Communication with non-physicians via phone, fax or e-mail. [6c]Consultant may respond to minor telephone request by e-mail.

[7a]Referring physicians can bill for telephone consultations with psychiatrists only. [7b]Remote communication from other healthcare providers. [7c]Billable by psychiatrists if response is made within 48 hours. [7d]Billable by psychiatrists if response is made within 2 hours.

[8a]Only dermatologists and ophthalmologists can bill "E-Assessments," an opinion and/or recommendation provided electronically through a secure server (e.g., secure messaging, electronic medical record). The consultant may choose to return their opinion by telephone; however, a written opinion must be provided electronically or by mail. These specialties can bill $44.45 and $45.85, respectively. [8b]This is the weighted average cost per eConsult based on the pro-rated payment for the Champlain BASE™ Service. [8c]Billable only when patient is referred by a physician or an NP.

[9a]Billable only by a referring physician who is a specialist. [9b]Billable when initiated by a pharmacist. [9c]Billable when initiated by a specialist or a non-physician (not billable when initiated by a GP). [9d]Billable by psychiatrists only.

[10]Gastroenterology (GI) pilot only – in place since April 2013. The in-person consultation fee is for GI specialists only.

[11]Only for internal medicine, pediatrics, dermatology and out-of-province specialists.

[12]Consulting specialists are paid on a pro-rated basis of $200/hour (average consult is 15 minutes).

Discussion

Remote consult is a win-win-win for all involved: patients gain quicker access to specialist advice through primary care, often preventing unnecessary referrals to specialty care; referring providers gain knowledge at the point of care to advance more effective patient care (including knowledge they may use toward future cases, where appropriate) and consultants are able to spend more time with those patients who benefit the most from an in-person visit (telephone consults require less time than in-person consults, and eConsults may be addressed after clinic hours).

From a physician remuneration perspective, fee-for-service (FFS) compensation ranges are greater for in-person versus remote consults, with in-person consult fees spanning from $50.51 to $468.00, whereas remote consult fees range from $10.10 to $135.13 (telephone consult fees range from $12.50 to $135.13 and eConsult fees range from $10.10 to $76.27) (Table 1). Overall, all but one jurisdiction (NB) has existing fee codes to compensate for remote consults (either telephone or eConsult). Ten jurisdictions have specific telephone consult fee codes (granted, 11 accommodate it, given existing salaried arrangements), whereas seven jurisdictions have specific eConsult fee codes (granted, nine accommodate it, given existing salaried arrangements).

Of note, current FFS approaches are helping to spread remote consult solutions. However, this approach ought not preclude a move to alternate funding plan (AFP) models – wherein physicians receive blended payments through a base salary, incentive/premium payments and additional fee-for-service. Best evidence suggests AFP is likely the way of the future for physician remuneration in general (see Report of the Advisory Panel on Healthcare Innovation, 2015, "Improving Value in Healthcare, Moving Away from Fee-for-Service: a Long Goodbye," p. 86).

Current remote consult practice – based on analysis by Champlain BASE™ eConsult, a secure web-based eConsult service launched within the Champlain Local Health Integration Network in Ontario – indicates that for consultants, a pro-rated hourly rate may be the most cost-effective approach; while for referring physicians, compensation may not be necessary given they are currently not compensated for requesting in-person consults (Liddy et al. 2016). The Champlain BASE™ implementation experience also lends guidance for those initiating remote consults without a compensation model in place: for the first six months of operations, an estimated cost per case of $50 is often sufficient (Liddy et al. 2016).

To encourage the spread and scale of innovative solutions, such as remote consult, remuneration should be implemented in a manner that supports the principle that payment follows the patient. This patient-centred care approach may require flexibility in terms of the funding arrangements so that cross-provincial and interjurisdictional remote consults are remunerated. Currently, there is variation for out-of-province physician billing. In AB, SK, NS and PE, consultants may bill for remote consult requests from out-of-province physicians. In BC, ON and MB, providing advice to physicians who are outside the province is an uninsured service, with the exception of telephone consults in BC as these are eligible for reciprocal billing. For the territories, the location of the specialist performing the consultation is not specified, supporting the assumption that some specialists are likely providing the consult service from another jurisdiction.

Finally, with the increasing burden of chronic disease and medically complex patients, there is a need to consider remuneration models enabling remote access to team-based care, in which the consultant may not always be a medical specialist but another regulated healthcare professional, such as a clinical pharmacist, wound care nurse, addiction counsellor or other. Likewise, to better support access for northern and remote communities, there is a need to explore remote consult for community-based health workers who are not physicians but who represent first-line healthcare access for regions without family doctors.

This patient-centred approach will enable more equitable access to specialist advice for all people across Canada, including in northern and remote communities, who often have the greatest need.

Conclusion

Remote consult offers considerable gains for all involved, especially patients – shortening wait times for specialists, preventing unnecessary specialist referrals and supporting more effective primary care management by enhancing access to specialist advice. Successfully scaling remote consult requires, among other things, consideration of physician remuneration, which may further support Canada's move in this direction. HQ

Acknowledgements

The authors thank provincial medical associations and government sources who informed this work. We also thank those who reviewed this article: Mr. Fraser Ratchford, group program director at Canada Health Infoway; Ms. Margot Wilson, director, chronic disease management strategy at Providence Health Care in Vancouver and Dr. Garey Mazowita, past president, College of Family Physicians of Canada. Margot and Garey are also lead faculty with the Connected Medicine collaborative.

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