Draft CPSO Continuity of Care Policies

OMA Member Consultation Guide

July 2018

Draft CPSO Continuity of Care Policies – OMA Member Consultation

Introduction and Purpose

There is a shared desire between physicians and patients to improve the co-ordination of care in Ontario's health-care system. Doing so requires a meaningful partnership with physicians to understand the day-to-day realities of delivering medical care in the province. In fall 2017, OMA Council recognized a need for better care co-ordination by endorsing a motion to establish referral expectations and obligations between physicians.

In 2016, the College of Physicians and Surgeons of Ontario (CPSO) started to develop policy on continuity of care. The OMA responded to a preliminary consultation in October 2016 and identified that while physicians already take steps to maximize their availability, consideration needs to be given to the system issues that impact continuity of care. Furthermore, the OMA asserted that physician health cannot be compromised and discussions of continuity of care must contemplate a reasonable degree of work-life balance. The OMA called on the CPSO to advocate on behalf of patients for the provision of adequate resources to ensure that physicians are enabled to provide continuity of care. The College should also advocate for physician well-being and strive to find a balance between the two.

On May 29, 2018, the OMA informed members that the CPSO had developed a draft umbrella continuity of care policy, along with discrete policies on: availability and coverage; managing tests; transitions in care and walk-in clinics. A summary of the proposed requirements for physicians is included (see Appendix A below). The CPSO indicates that it is aiming to address elements of continuity of care that are within the control of physicians. A CPSO white paper addressing system-level issues impacting continuity of care is expected in the future.

The OMA requested, among other things, for the CPSO Council to endorse a six-month consultation window. This request was agreed to and feedback is due in December 2018. Given the potential impact of the policies, it is essential that physicians are provided with ample opportunity to consider them. As the representative of Ontario's physicians, the OMA will solicit member input and provide a written response to the CPSO. Other activities will be contemplated as the consultation process with members unfolds.

The purpose of this document is to provide a summary of the proposed requirements for physicians (Appendix A), and stimulate discussion by sharing key issues that have been raised by OMA staff when reviewing the policy and provide guiding questions to facilitate consultation. It is noted that the CPSO has also launched its own consultation process with physicians and the OMA encourages members to submit your thoughts directly to the CPSO as well. You can learn more at:
http://policyconsult.cpso.on.ca/?page_id=10258

Key Areas Identified By Staff

OMA staff have reviewed the draft policies and identified several key areas for members' consideration. This list is not exhaustive – the aim of the consultation is to solicit physician input regarding elements of the policy that the OMA:

1. Should aim to support.

2. Elements that we could support with the appropriate staging and/or resources provided.
3. Elements that are not reasonable.

You are encouraged to review Appendix A and/or the draft policies in their entirety.

Managing Tests[a]

The CPSO is proposing that physicians be available 24/7 to respond to critical test results.

Physicians would be required to track test results for high-risk patients and this includes verifying whether the patient has taken the test and ensuring the result is sent to the physician.

Physicians are advised to provide contextual information on the requisition form and must copy the patient's primary care provider, along with ensuring patient contact information is correct at every visit. Physicians utilizing a "no news is good news" strategy for test results would be required to tell patients they have the option to personally contact the physician's office for the test result.

Availability and Coverage

It is proposed that physicians co-ordinate after-hours care and care for patients during temporary absences, making reasonable attempts to minimize unco-ordinated access to care and inappropriate utilization of emergency rooms or walk-in clinics.

Physicians would be expected to maintain an active telephone line or voicemail and structure their practice to enable triaging of patients with time-sensitive issues.

Further, physicians would be required to respond in a timely manner to other health-care providers.

Transitions in Care

The policy asks referring physicians to schedule specialist appointments directly with patients.

Several responsibilities for physicians in hospitals are outlined. For example, physicians handing over patient care are strongly advised, wherever possible, to have a real-time and personal exchange of information, discussion and time to answer questions.

Walk-In Clinics

Physicians practising in a walk-in clinic would be required to provide the patient's primary care provider with a record of the encounter.

Walk-in clinic physicians are advised to offer comprehensive primary care to orphaned patients unable to locate a primary care provider.

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[a] *Much of the content of the current Test Results Management policy has been retained in the draft policy, with some clarifications and additions. The current Test Results Management policy can be accessed at: https://www.cpso.on.ca/Policies-Publications/Policy/Test-Results-Management*

Guiding Questions

The following questions are meant to solicit OMA member input and inform the OMA's formal response to the CPSO.

1. Are there additional key areas, from a physician perspective, that are missing from the policy?
2. Are there additional key areas, from a physician perspective, that have not been identified by staff?
3. What areas of the proposed policies are reasonable and should be pursued?
4. What resources, support and/or staging would be required to implement the proposed policies?
5. On a prioritized basis, what are the key issues that absolutely need to be amended or eliminated?
6. Where are the gaps in the proposed policies?

Members and member representatives (e.g. Sections/Districts) are welcome to submit comments to the OMA at: COC@OMA.org by August 1st 2018.

Appendix A – Summary

The CPSO has produced a "suite" of draft policies on continuity of care. The suite is composed of four draft policies addressing specific practice areas and organized under an umbrella draft policy. Each draft policy is summarized at a high-level below. Note that this memo is staff's attempt to provide members with a flavour of the proposed policy being considered by the CPSO. Many specifics/context information have been omitted and please see the full text[1] from the CPSO for more information.

1) **Continuity of Care** – This is the umbrella policy that sets forth a number of principles that physicians must abide by. Specifically, the CPSO aims to focus on issues within the control or influence of physicians. The College wants physicians to recognize that patient interactions within the health-care system are best viewed as interactions that require oversight and management. The draft policy requires physicians to engage patients in a manner that will supplement and support physicians' efforts to facilitate continuity of care (while not absolving physicians of their responsibilities). Lastly, the policy encourages physicians' use of technology to facilitate continuity of care.

2) **Availability and Coverage** – This draft policy states that individual physicians are not required to personally provide on-demand and continuous access to care. Rather, it focuses on physicians' obligations to be available/responsive and make plans or coverage arrangements when unavailable. The draft policy would require:

    a. Physicians must have an office telephone that is answered and/or a voicemail that allows messages to be left during operating hours and a voicemail that allows messages to be left outside operating hours. Voicemail messages must be reviewed and responded to in a timely manner, where timeliness depends on a variety of factors, including when the message was left (e.g., after-hours, weekend, holiday, etc.). The voicemail outgoing message must be accurate and up to date regarding practice hours, closures and coverage information.
    b. Physicians must structure their practice for appropriate triaging of patients with time-sensitive or urgent issues. This may include implementing same-day scheduling or utilizing other providers.
    c. Physicians must respond in a timely and professional manner when contacted by providers who want to communicate or request information pertaining to a patient (e.g., test results and prescription clarifications). Timeliness will depend on the degree to which the information impacts patient safety. To facilitate access and enable communication, physicians must include their professional contact information when ordering a test, writing a prescription or making a referral.
    d. Primary care physicians and specialists who have a sustained physician-patient relationship that is managed over multiple encounters must have a plan in place to co-ordinate care for their patients outside regular operating hours. Physicians must use their judgment to determine how to best structure their plan. The nature of the plan will depend on a variety of factors, including the health-care provider and/or health system resources in the community. All physicians who order tests must ensure that critical test results can be received and responded to 24/7 (coverage arrangements are permissible). Physicians must also co-ordinate care for their patients during temporary absences from practice. To do so, physicians must arrange for another provider to provide care during these absences. The

nature of this arrangement is variable depending on a variety of factors and physicians will need to use their judgment in establishing an appropriate arrangement.

e. Patients must be notified about the after-hours plan they have put in place. Physicians must also inform patients of coverage arrangements during temporary absences, but must use their professional judgment to determine whether to do this in advance or, for example, via voicemail during the absence.
f. Physicians are advised to grant access to patient health information to those providing coverage when the nature of the arrangement makes it possible.

3) **Managing Tests** – This draft policy requires physicians who order any type of test to have a test management system. The draft policy would require:

a. Physicians maintain a test results management system that at minimum contains all tests ordered; all test results received; record that all test results received have been reviewed; identification of high-risk patients and critical and/or clinically significant test results, and a record that the patient has been informed of a clinically significant result and follow-up action taken by the physician.
b. A patient's primary care provider must be copied on the test requisition form.
c. Physicians must track test results for high-risk patients (including verifying that the patient has taken the test and ensuring that the lab/diagnostic facility has sent the results to the physician).
d. When in receipt of a clinically significant test result, physicians must communicate the test result to the patient in a timely fashion. Physicians must use their professional judgement to determine how to best communicate a test result. Physicians do not necessarily have to personally communicate test results to the patient.
e. Physicians who want to use a "no news is good news" strategy for test results management must be confident that the test result management system in place is sufficiently robust to ensure that no test results will be missed. Physicians must also use professional judgment to determine when a "no news is good news" strategy is appropriate. For physicians who use this strategy, they must tell patients that they have the option to personally contact the physician's office for the test result.
f. Physicians (or staff) are advised to confirm that patient contact information is correct at each appointment; whether they accept voicemail messages and emergency contact information.
g. Physicians who receive (or incidentally become aware and have reason to believe the ordering provider will not get the test result) critical or clinically significant test results in error must inform the ordering health-care provider, the patient's primary care provider, or the patient of the test result. They must also inform the laboratory or diagnostic facility of the error.
h. Physicians must inform patients of the significance of tests, the importance of getting the test done and the importance of complying with the requisition form instructions.

4) **Transitions in Care** – This draft policy establishes expectations of physicians when patient care (or elements thereof) is transferred between physicians or other health-care providers. Specifically, physicians would be required to:

Keeping Patients Informed and Patient Handovers

a. Co-ordinate with other health-care providers to keep patients aware about who is their most responsible provider (MRP).
b. Referring physicians must clearly communicate to patients what their anticipated role will be in managing care during the referral process. Consultant physicians (meaning any physician who accepts referrals), must also discuss with the patient the nature of their role in providing care.
c. Physicians handing over care are strongly advised, wherever possible, to have real-time personal exchanges of information that includes an opportunity for discussion and for questions to be asked. Physicians are further advised to approach patient handovers in a systematic way.

Hospital Discharge

d. Prior to discharge from hospital, physicians must ensure that someone has discussed with the patient or their substitute decision-maker (SDM) about potential complications, monitoring signs/symptoms, whom to contact if complications arise, etc. Reasonable steps should be taken to involve other individuals in the discharge discussion when the patient/SDM would like them involved. Physicians must use their professional judgement to determine whether having elements of the discharge discussion captured in writing would be appropriate.
e. The MRP must complete and distribute a discharge summary for all in-patients in a timely manner. The CPSO identifies elements that must be included. The MRP must direct that the discharge summary is sent to the patient's primary care provider and take reasonable steps to identify other relevant health-care providers whose care delivery would benefit from this information and direct that it be sent to them as well.

Referrals

f. Referring physicians must take reasonable steps to confirm that the patient's condition(s) is (are) within the scope of practice of the consultant physician to whom they intend to refer the patient. Physicians are advised to be mindful of whether the consultant physician is accepting patients and whether the practice is accessible to the patient.
    i. Referrals must be made in writing and signed by the referring physician. The CPSO proposes elements that must be included in the referral.
    ii. Referring physicians must have a mechanism in place to track that the referral has been received and that an acknowledgment of the referral will be provided.
    iii. Referring physicians must respond in a timely and professional manner when contacted by a consultant physician who wants to communicate or request information pertaining to a patient. When making a referral for the purpose of a test, referring physicians must ensure that critical test results can be received and responded to 24/7.
    iv. Physicians who are asked to consult on a patient's care must acknowledge the referral within 14 days from the date of receipt.

v. If consultant physicians are able to accept the referral, they must provide an estimated or actual appointment date and time to the referring health-care provider. They must also indicate whether this information was communicated with the patient.
vi. If the consultant physician is not able to accept the referral, they must communicate their reasons for declining the referral. Where a consultation is urgently needed, consultant physicians must provide suggestions to the referring health-care provider of alternative providers who may be able to accept the referral.
vii. Referring physicians must communicate the estimated or actual appointment date and time to the patient, unless the consultant physician has indicated that they have already done so (or intend to).
viii. Consultant physicians must communicate any instructions/information to patients that they need in advance of the appointment, unless the referring physician has agreed to assume this responsibility. Consultant physicians must also communicate any changes in the appointment date and time with the patient directly and must allow patients to make changes directly with them.
ix. Following an assessment of the patient, consultant physicians must prepare a report. CPSO specifies what needs to be included. When consultant physicians are involved in the provision of ongoing care, they must also prepare follow-up reports when there are new findings or changes made to the management plan. Consultant physicians must distribute their consultation report and follow-up reports in a timely manner no later than 30 days after. Consultant physicians must send reports to the referring health-care provider, patient's primary care provider and take reasonable steps to identify others who are relevant and send them the report as well.

5) **Walk-In Clinics** – This draft policy sets out the CPSO's expectations for physicians practising in walk-in clinics that relate to continuity of care. This includes urgent care centres, but not hospital emergency rooms. Proposed requirements include:

a. Patients may not be aware of the limits to the types of care that can be provided at a walk-in clinic setting. As such, physicians must use their professional judgment to determine whether it would be appropriate to sensitively remind patients about the benefits of having/seeing a primary care provider as well as the limits of walk-in clinic care. Physicians in walk-in clinics should be as helpful as possible in supporting patients to find a primary care provider.
b. Physicians practising in walk-in clinics must meet the standards of the profession, regardless of whether care is being provided in a sustained or episodic manner. This means conducting any assessments, tests or investigations that are required to treat the presenting concern(s) and providing any follow-up care that may be required.
c. Physicians practising in walk-in clinics must maintain a test management system to ensure that appropriate follow-up occurs for all tests ordered. It is not appropriate to rely on the patient's primary care provider or another provider in the patient's care to provide or co-ordinate follow-up for tests or referrals, unless they have explicitly agreed to assume this responsibility.
d. Physicians practising in a walk-in clinic must comply with the requirements in the proposed *Availability and Coverage* policy (e.g., 24/7 availability arranged for critical test results).

e. Physicians practising in a walk-in clinic must provide the patient's primary care provider with a record of the encounter. These physicians should also take reasonable steps to identify other relevant health-care providers whose care delivery would benefit from this knowledge.
f. In instances where patients experience difficulty finding a primary care provider and regularly attend the same walk-in clinic for primary care needs, physicians practising in walk-in clinics are advised to offer, within their scope of practice and in co-ordination with other physicians in the practice, comprehensive primary care to the patient as an interim measure.
    i. This comes with additional requirements (e.g., co-ordinating after-hours access and arranging coverage during temporary absences).

[1] CPSO Continuity of Care Consultation: http://policyconsult.cpso.on.ca/?page_id=10258