February 10, 2017

Summary of feedback, comments and questions regarding Accepting new patients draft policy for the CPSO:

The following information is feedback given on behalf of the Care Connector team from the Health Care Connect Program, on the draft policy for physicians on "Accepting New Patients".

The intent is to provide feedback on clarity in language and identify any possible gaps identified by the Care Connectors.

The draft policy continues to maintain the overarching principle of First Come First Served basis, whereby physicians accept patients on a first come first served approach. The new draft policy provides further clarity on the principles and scope when accepting patients in a fair and transparent manner. The policy applies to all physicians practicing in Ontario, including specialty care.

NOTE: The comments and feedback outlined in this document are provided by the provincial Care Connectors of the Health Care Connect Program, based on their experience and observations in working within their scope and role as Care Connectors. This document is independent of the views of the Ontario Ministry of Health and Long Term Care and the Community Care Access Centres of Ontario.

Principles:

Line 25: ***"Respecting patient autonomy and a patient's freedom of choice of health-care provider- newly added principle"***.-Suggestion made to consider changing the wording. Can this be interpreted as enabling patients to 'doctor shop'? Should there be further clarification to prevent patients from discriminating a provider who is willing and able to accept them?

- Patients have the autonomy to choose provider if available and has capacity.
- Helpful for patients in rural communities where there aren't many options available regularly.

Scope:

Scope has been broadened when compared to the current policy. In the new policy, scope expands to all physicians including specialty care.

Line 32: ***"This policy applies to all physicians, and those acting on their behalf…"*** Suggestion made to move footnote 1 within the body of the policy for further clarity.

Line 37: '*A physician-patient relationship that exists for a defined period of time"*-Suggestion made to provide example to provide further clarity—specialist care or walk-in provider care.

Policy:

Lines 62-64: Suggestion—Include language that clarifies whether or not this applies to providers in the context of primary care and/or specialty area. This may be confusing as general practitioners should be able to accept all patients if they have capacity, and the physician does not have an area of specialty/focused area.

Lines 67-70: *"…inappropriate, for physicians to use introductory meetings such as 'meet-and-greet' appointments…"*--Suggestion made to expand wording to provide further clarity. For instance, provide example when to use meet and greets and questionnaires (only after having been accepted by provider) and how they can be used to learn more about practice functions, or to get to know patient/provider better.

Q: **Do lines 100-101 contradict with lines 62 & 90?** Suggestion to further clarity on language around ability to accept not decline patients based on physician's clinical competency. What makes a provider 'not competent' to take on the patient?

Lines 109-110: Suggestion-to indicate that reasons for refusal must be clearly communicated to the patient by the physician or those acting on their behalf. (Provide suggestion on how this would be communicated to the patient).

Lines 118-121: 'Where clinical competence and/or scope of practice limit the types of services a physician provides, patients seeking care must not be abandoned…."-Suggestion made to move this near the front near line 93.

Waiting Lists:

Team identified need to review process of HCC waitlist management process and the new waitlist management principles of this policy.

Line 138: Suggestion-indicate physician or someone acting on their behalf, needs to communicate to patients when and if they might be accepted if they are on the waitlist.

Clarity around administering a questionnaire can be part of a patient's intake after the initial appointment not while on a waitlist.

Additional Comments/Questions:

1. How will the new policy be enforced with the physicians?

2. How does the CPSO foresee the implementation of the First come first serve approach to accepting new patients? Are they anticipating physician groups to manage their own waitlists?

3. What is the implementation strategy for providers and partners (ex. Providers working with community partners, other health professionals, public)?

4. How will the implementation of the new policy be assessed for provider compliance and accountability?

5. How can partners help support the new policy? (ex. other colleagues, health professionals, community partners working with providers).

6. Suggestion made to develop an FAQ including different scenarios and examples where appropriate, to provide guidance for providers, partners, and the public to better understand and support the new policy.

7. Consider adding language for guidance around patients who are unable to keep appointments and are declined for enrolment in a practice as a result. ("no show policy).

8. Include language around preserving patient privacy and confidentiality in all circumstances (before accepting and after accepting patient to the practice).

9. How will the new policy support the application process for provider offices where patients complete a questionnaire online, or in office, in order to get enlisted onto the waitlist?

10. How would the HCC waitlist, based on health care need vs the policy of first come first serve, work together?

11. What would be the process for members of the public to report concerns regarding the compliance of the new policy enforcement of a provider?

12. What would be the process for partners to report concerns regarding the compliance of the new policy enforcement of a provider on behalf of the patient/public?

13. What happens when patients get accepted into a physician's practice and they are on multiple lists? Other offices may continue to try and contact the patient (using time and resources). If it is a small community with one or two FHT groups, will patients have to apply directly to both? Once this policy is in place, there is anticipation of having an increase number of calls from patients asking where they are on the list and what the wait time will be.

14. How might this policy come into effect should a family physician chooses to "specialize" into a specialty area? (ex. Geriatrics, psychotherapy etc). Does this then exempt these providers from this policy? How may this affect patients who might be seeking a family physician?

15. Consider to include exemptions, or provide clarity in the scenario where the health and well- being of a patient is being compromised by waiting (ex. New pregnant mom; recent diagnosis of a chronic disease or cancer. Even though these patients may be going to a specialist, other health issues may not get addressed by the specialist and hence would benefit from having access to a primary care provider sooner. Another example of considering prioritization on accepting pts to primary care would be for patients requiring a referral for mental health support/specialist, chronic pain clinic, and those recently discharged from hospital.