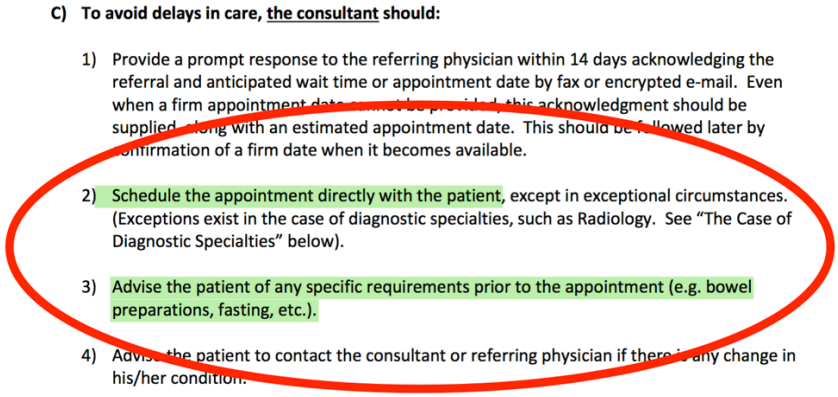
To whom it may concern:

Recently, I was alerted to a policy that the CPSO is drafting regarding "Continuity of Care" as can be found on page 186 of the CPSO's Annual Financial Meeting of Council[1] for May 24 and 25, 2018.

I have serious concern regarding a proposed requirement in Appendix D, "Transitions in Care" section. Specifically, on page 234, under the section of "Communicating with Patients", Line 211 directs that *"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 do so."*

I was alarmed to find to that the the CPSO is drafting a directive that is in direct contrast to that of the already existing, comprehensive policy of the College of Physicians and Surgeons of Nova Scotia[2], where on page 2 they state that the consultant physician "should schedule the appointment directly with the patient":



C) To avoid delays in care, the consultant should:

1) Provide a prompt response to the referring physician within 14 days acknowledging the referral and anticipated wait time or appointment date by fax or encrypted e-mail. Even when a firm appointment date cannot be provided, this acknowledgment should be supplied along with an estimated appointment date. This should be followed later by confirmation of a firm date when it becomes available.

2) Schedule the appointment directly with the patient, except in exceptional circumstances. (Exceptions exist in the case of diagnostic specialties, such as Radiology. See "The Case of Diagnostic Specialties" below).

3) Advise the patient of any specific requirements prior to the appointment (e.g. bowel preparations, fasting, etc.).

4) Advise the patient to contact the consultant or referring physician if there is any change in his/her condition.

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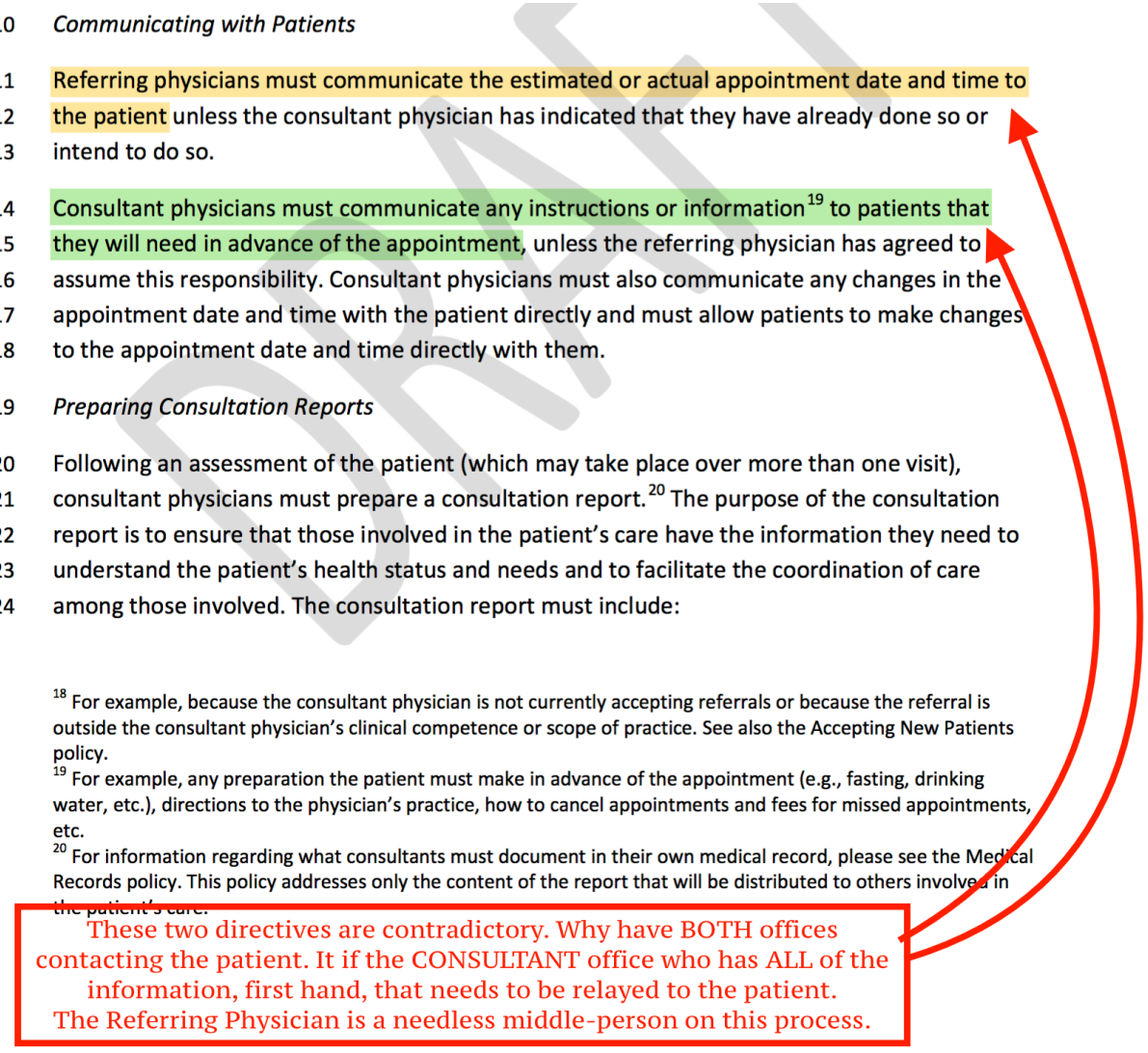
In the interest of patient care, it is far more efficient, timely, and accurate, if the consultant physician schedules the appointment directly with the patient. It is the consultant physician who has direct knowledge of the appointment time, and alternative options if the appointment is not agreeable for the patient or if it should need to be rescheduled. It would be a redundant, needless, intermediary step to for the referring physician to have to relay information from the consultant to the patient.

Furthermore, on Line 214 of the CPSO's same policy, the CPSO is directing that the consultant physician, quite appropriately, be the one to notify the patient of any instructions or preparation prior to the appointment. Here, the policy is directing conflicting, redundant effort. In the interest of patient care, it should be the consultant physician who contacts the patient for *all* of this information in a single communication:



210 *Communicating with Patients*

211 Referring physicians must communicate the estimated or actual appointment date and time to
212 the patient unless the consultant physician has indicated that they have already done so or
213 intend to do so.

214 Consultant physicians must communicate any instructions or information[19] to patients that
215 they will need in advance of the appointment, unless the referring physician has agreed to
216 assume this responsibility. Consultant physicians must also communicate any changes in the
217 appointment date and time with the patient directly and must allow patients to make changes
218 to the appointment date and time directly with them.

219 *Preparing Consultation Reports*

220 Following an assessment of the patient (which may take place over more than one visit),
221 consultant physicians must prepare a consultation report.[20] The purpose of the consultation
222 report is to ensure that those involved in the patient's care have the information they need to
223 understand the patient's health status and needs and to facilitate the coordination of care
224 among those involved. The consultation report must include:

[18] For example, because the consultant physician is not currently accepting referrals or because the referral is outside the consultant physician's clinical competence or scope of practice. See also the Accepting New Patients policy.
[19] For example, any preparation the patient must make in advance of the appointment (e.g., fasting, drinking water, etc.), directions to the physician's practice, how to cancel appointments and fees for missed appointments, etc.
[20] For information regarding what consultants must document in their own medical record, please see the Medical Records policy. This policy addresses only the content of the report that will be distributed to others involved in the patient's care.

These two directives are contradictory. Why have BOTH offices contacting the patient. It if the CONSULTANT office who has ALL of the information, first hand, that needs to be relayed to the patient. The Referring Physician is a needless middle-person on this process.

One can only imagine the administrative and communicative chaos when the Referring Physician is an Emergency Physician, for instance. Is it the CPSO's intent to have Emergency Physicians fax referrals to consultants; then have the consultant contact the Emergency Department with an appointment time; then wait for that Emergency Physician to return to the department for her/his next shift; then have have Emergency Department contact the patient? What if the given appointment is not agreeable for the patient and then needs to be rescheduled?

Unrelated, in Ontario's Schedule of Benefits[3], on page 9 of the General Preamble, it explicitly specifies that it is the responsibility of the billing physician, in this case the consultant physician, to "make arrangement for appointments for the insured service":

COMMON ELEMENTS OF INSURED SERVICES

All insured services include the skill, time, and responsibility involved in performing, including when delegated to a non-physician in accordance with the Delegated Procedures Section (GP42) of the General Preamble, supervising the performance of the *constituent elements* of the service.

Unless otherwise specifically listed in the Schedule, the following elements are common to all insured services.

A. Being available to provide follow-up insured services to the patient and arranging for coverage when not available.

B. Making arrangements for appointment(s) for the insured service.

If consultant is billing a consult/procedure code, she/he is explictitly required ot schedule the appt

C. Travelling to and from the place(s) where any element(s) of the service is (are) performed.

[Commentary:
Travelling to visit an insured person outside of the usual geographical area of practice of the person making the visit is an *uninsured service* – see Regulation 552 section 24(1) paragraph 1 under the Act.]

D. Obtaining and reviewing information (including history taking) from any appropriate source(s) so as to arrive at any decision(s) made in order to perform the elements of the service.

Appropriate sources include but are not limited to:

1. patient and *patient's representative*
2. patient charts and records
3. investigational data
4. physicians, pharmacists, and other health professionals
5. suppliers and manufacturers of drugs and devices
6. relevant literature and research data.

E. Obtaining consents or delivering written consents, unless otherwise specifically listed in the Schedule.

F. Keeping and maintaining appropriate medical records.

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This is appropriate given that, since it is is the consultant physician who is generating the revenue from the service in question, then it should be the consultant who also incurs the administrative burden and overhead costs associated with the service. I cannot fathom a business model in which this would not be the case.

In summary, for all of the reasons above, I implore the CPSO the revise its proposition on this matter. Specifically, in the CPSO's draft policy on "Continuity of Care", under Appendix D, "Transitions in Care", under the "Communicating with Patients" section, on Line 211, that it specify **the "Consultant physician must communicate the estimated or actual appointment date and time to the patient."**

References:

1. http://www.cpso.on.ca/CPSO/media/documents/Council/Council-Materials_2018May_1.pdf
2. https://cpsns.ns.ca/wp-content/uploads/2017/10/Referral-and-Consultation.pdf
3. http://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master11062015.pdf