Continuity of Care: Transitions in Care

Executive Summary

This policy sets out the College's expectations of physicians when patient care or an element of patient care is transferred between physicians, or between physicians and other health-care providers. Key topics and expectations include:

- *Keeping Patients Informed*: Within hospitals and health-care institutions physicians must coordinate with others to keep patients informed about who is their most responsible provider. When referrals are made, both referring and consultant physicians must inform patients about the nature of their role and keep patients updated if their role changes.
- *Managing Handovers in Hospitals and Health-Care Institutions:* Physicians are advised to approach patient handovers in a systematic manner and to set time aside to allow for a real-time and personal exchange of information between health-care providers.
- *Completing and Distributing Discharge Summaries:* The most responsible physician must complete a discharge summary for all in-patients in a timely manner. If a delay in distribution is anticipated, the most responsible physician must provide a brief summary directly to those health-care providers responsible for follow-up care.
- *Making and Acknowledging a Referral:* Referring physicians must make a referral in writing and consultant physicians must acknowledge a referral request in a timely manner, urgently if necessary, but no later than 14 days from the date of receipt.
- *Distributing Consultation Reports:* Consultation reports must be distributed in a timely manner, but no later than 30 days, following an assessment of the patient or when there are new findings or changes in the management plan.

Purpose and Scope

This policy sets out the College's expectations of physicians when patient care or an element of patient care is transferred between physicians, or between physicians and other health-care providers. This includes expectations in relation to keeping patients informed about who is responsible for their care, patient handovers within a hospital or health-care institution, discharges from hospital, and the referral and consultation process.

Policy

When responsibility for patient care or an element of patient care is transferred between physicians, or between physicians and other health-care providers, breakdowns in continuity of care may occur that can negatively impact patient health outcomes and the quality of care provided. Physicians have a role to play in facilitating continuity of care during transitions by

helping to keep patients informed about who is responsible for their care, facilitating the timely exchange of information between health-care providers, and coordinating transitions by collaborating with both patients and other health-care providers.

Keeping Patients Informed

Patients are often provided care by a number of health-care providers and keeping patients informed about who is responsible for their care or an element of their care is an important component of quality care. How physicians support patients in this regard will depend on their practice setting and their role in managing patient care.

Hospitals and Health-care Institutions

In a hospital or health-care institution, patient care is often provided by a team of health-care providers, and who the most responsible provider[1] is may regularly change. In these instances it can be difficult for patients to know who is responsible for their care. Physicians must coordinate with other health-care providers to keep patients informed about who is their most responsible provider.

Referring and Consultant Physicians

Referring physicians must clearly communicate to patients what their anticipated role will be in managing care during the referral process. This includes how patient care and follow-up may be managed and by whom.

Consultant physicians[2] must also discuss with patients the nature of their role in providing care to patients. This includes explaining which elements of care they are responsible for, and the anticipated duration of care. When it is possible to do so, consultant physicians must also clearly communicate when their relationship has reached its natural conclusion or when it is anticipated that it will reach its natural conclusion to help patients understand when the treating relationship ends.[3]

If there are any changes in these responsibilities, both referring and consultant physicians must keep patients informed about their changing role.

[1] Recognizing that the scopes of practice of other health-care providers are evolving and that other health-care providers may have overall responsibility for managing patient care, this section of the policy has adopted the term "most responsible provider" as opposed to "most responsible physician" (see the Canadian Medical Protective Association's "The most responsible physician: a key link in the coordination of care" for more information).
[2] This policy uses the term "consultant physician" in order to capture any physician, including primary care physicians, who accept referrals.
[3] See also the Ending the Physician-Patient Relationship policy.

Managing Handovers in Hospitals and Health-Care Institutions

Effective patient handovers equip those assuming responsibility for patient care with the information they need to appropriately manage that care. In order for this to occur, there needs to be a timely exchange of information, where the information exchanged is accurate, complete, and unambiguous, and where the health-care provider assuming responsibility has understood the information that has been exchanged.[4] Physicians have an essential role to play in ensuring that patient handovers are effective.

Physicians handing over patient care to another health-care provider are strongly advised, wherever possible, to have a real-time and personal exchange of information that includes an opportunity for a discussion to occur and for questions to be asked.[5] Physicians are also advised to approach patient handovers in a systematic manner and to set time aside for the information exchange process. This may mean, for example, utilizing standardized or structured communication approaches or tools[6] that help focus information sharing practices.

Discharging patients from hospital

Transitions from hospital to the community present a number of challenges for both patients and health-care providers providing care in the community, and breakdowns in continuity of care may occur. While other health-care providers may play a role in the discharge process and the coordination of supports in the community, this policy will focus on the role physicians play in preparing patients for discharge from hospital,[7] as well as their role in completing and distributing discharge summaries.

Preparing Patients for Discharge

Prior to discharging a patient from hospital, physicians must ensure that they or a member of the health-care team has a discussion with the patient and/or substitute decision-maker about:[8]

[4] The Canadian Medical Protective Association provides advice on managing handovers as well (see their "Improving patient handovers").

[5] This may occur via an in-person exchange, but may also be achieved through a telephone call, video conferencing or other e-communication technology so long as doing so complies with physicians' legal and professional obligations to protect the privacy and confidentiality of the patient's personal health information (see the Confidentiality of Personal Health Information policy and *PHIPA*).

[6] A number of tools have been developed to standardize and systematize patient handovers. This includes, for example, SBAR, I-PASS, or I START-END. The College does not endorse any specific approach or tool, recognizing that a variety of methods can facilitate the same successful information exchange.

[7] This policy addresses only those issues that arise in relation to a discharge from hospital. Information on discharging of patients from, for example, an Out of Hospital Premise or Independent Health Facility (or what will soon be called Community Health Facilities) can be found the College's website.

[8] See also the Canadian Medical Protective Association's "Discharging patients following day surgery".

- Post treatment or hospitalization risks or complications;
- Signs and symptoms that need monitoring and when action is required;
- Whom to contact and where to go if complications arise;
- Instructions and recommendations to the patient and/or substitute decision-maker with respect to managing post-discharge care, including medications (e.g., frequency, dosage, duration); and
- Information about any follow-up appointments or outpatient investigations that have been or are being scheduled, or that the patient is responsible for arranging and a timeline for doing so.

Involving the patient's family and/or caregivers[9] in discharge discussions may benefit both the patient and those involved in managing the patient's post-discharge care. Physicians must take reasonable steps to facilitate the involvement of these individuals in the discharge discussion when patients or substitute decision-makers indicate that they would like them involved and provide consent to disclose personal health information.[10]

There may be instances where the patient and/or substitute decision-maker would benefit from having elements of the discharge discussion captured in writing in order to support their ability to recall and act on that information once discharged. Physicians must use their professional judgment to determine both whether this discussion should be accompanied by written reference materials and the specific nature of those materials. Factors that physicians must consider when making these determinations include, but are not limited to: the health status and needs of the patient; any post treatment risks or complications; the need to monitor signs or symptoms; whether follow-up care is required; any language and/or communication issues that may impact comprehension;[11] and whether the recipient of the information is experiencing stress or anxiety which may impair their ability to recall and act on the information shared.

Completing Discharge Summaries

The most responsible physician must complete a discharge summary for all in-patients. In order to facilitate continuity of care, physicians must complete the discharge summary in a timely

[9] Caregivers may be formal or informal, and may include, for example, family and/or others close to the patient.
[10] For more information on physicians obligations relating to the disclosure of personal health information, see the Confidentiality of Personal Health Information policy and *PHIPA*.
[11] See the Consent to Treatment policy and Frequently Asked Questions document for guidance on addressing language and/or communication barriers.

manner. What is timely will depend on the patient's condition and the urgency associated with their follow-up care needs.[12]

The purpose of the discharge summary is to equip those health-care providers responsible for post-discharge care with the information they need to understand the admission, the care provided, and the patient's health-care condition and needs. The discharge summary must be signed and dated by the most responsible physician and must include:

- Identifying information, including the most responsible physician's name, the author's name and status if different than the most responsible physician, the patient's name and health record number, and the admission and discharge dates;
- The reason(s) for the admission and the patient's discharge diagnosis;
- A brief summary of how each active medical problem was managed, including any major investigations, treatments, and outcomes;
- Details regarding any discharge medications (e.g., frequency, dosage, durations), any changes to ongoing medication, and the reasons for giving or altering medications; and
- Follow-up care needs and recommendations, as well as a list of scheduled appointments, any further outpatient investigations, and any outstanding test or investigation results or consultant reports.

Physicians must avoid using terminology, acronyms, or abbreviations in the discharge summary that are known to have more than one meaning in a clinical setting or that might cause confusion among those health-care providers receiving the discharge summary.[13]

Distributing Discharge Summaries

The timely distribution of a discharge summary is an essential element of continuity of care and delays in distribution may expose patients to adverse clinical outcomes. If a delay in distribution of the discharge summary is anticipated, the most responsible physician must provide a brief summary of the admission and discharge directly to those health-care providers responsible for follow-up care in a timely manner to ensure they have the information they need to provide post-discharge care. Additionally, when the required follow-up care is time-sensitive or the patient's health condition requires close monitoring, the most responsible physician must also consider whether direct communication with the health-care provider assuming responsibility is warranted.

[12] Physicians are reminded that they must complete the discharge summary within 48 hours of discharge in order to bill the Ontario Health Insurance Plan for a patient visit on the day of discharge.
[13] This is consistent and builds upon the general requirements set out in the Medical Records policy.

The most responsible physician must direct that the discharge summary be sent to the patient's primary care provider.[14] The most responsible physician must also take reasonable steps to identify other relevant health-care providers whose ongoing care of the patient would benefit from knowledge of the hospitalization and direct that the discharge summary be sent to them as well.[15]

Referring Patients and Consulting on Patient Care

Breakdowns in care may occur during the referral and consultation process when there are unnecessary delays in receiving the care the patient needs or where there is a breakdown in the information exchange and communication between health-care providers. As such, physicians have a role to play in coordinating these transitions to facilitate continuity of care.

Planning for a Referral

In order to minimize unnecessary delays that may compromise patient safety, 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. This may involve, for example, being mindful of sub-specialties and/or areas of focus to which physicians may choose to limit their practice. Physicians are also advised to be mindful of whether the consultant physician is accepting patients and whether the consultant physician's practice is accessible to the patient (e.g., location, physical accessibility, etc.).

Making a Referral

Referrals[16] must be made in writing[17] and signed by the referring physician. If urgent, a verbal request may be appropriate, but must be followed by a written request. If the referring and consultant physician have access to a common medical record, the written request may be made and contained in that medical record. Otherwise, both the referring and consultant physicians must keep a copy of the written request in their respective medical records.

[14] Under *PHIPA*, physicians can assume they have patient consent to share personal health information with those in the patient's circle of care unless the patient has expressly withdrawn their consent to do so.
[15] See Footnote 14.
[16] The expectations set out in this policy apply broadly to all referrals with the exception of effective referrals that are made when physicians choose to limit the services they provide for reasons of conscience or religion. Specific expectations for effective referrals are set out in the Professional Obligations and Human Rights and Medical Assistance in Dying policies.
[17] A referral may be made electronically or in paper form.

All referrals must include:

- Identifying information, including the name and contact information of the referring physician, primary care provider (if different than the referring physician), consultant physician, and patient;
- Reason(s) for the consultation, as well as any information the referring physician is seeking and/or questions they would like answered;
- Where relevant, the referring physician's sense of the urgency of the consultation; and
- Summary of relevant medical history, including current medications and copies or summaries of all relevant test and procedure results.

Where referring and consultant physicians have access to a common medical record, a brief summary of the relevant medical history may be appropriate provided that the referring physician clearly indicates which elements of the common medical record (e.g., medications, test results, etc.) must be reviewed.

Tracking a Referral

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. The urgency of the referral will determine the degree to which the referring physician must monitor the referral request. Referring physicians are also advised to engage patients in this process by, for example, informing patients that they may follow-up with the referring physician if they have not heard anything within a specific time frame.

Being Available to Consultant Physicians

When making a referral, physicians must also comply with relevant expectations set out in the Availability and Coverage policy. For example, 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 the patient (e.g., to clarify a referral request, urgently communicate findings). Additionally, when making a referral for the purposes of a test, referring physicians must ensure that critical test results can be received and responded to 24 hours a day, 7 days a week.

Acknowledging a Referral

Physicians who are asked to consult on a patient's care must acknowledge the referral in a timely manner, urgently if necessary, but no later than 14 days from the date of receipt. How quickly consultant physicians must acknowledge the request will depend on the patient's condition and their need for a consultation, including whether a delay in acknowledgement

may expose the patient to any adverse clinical outcomes. When acknowledging the referral, consultant physicians must indicate whether or not they are able to accept the referral.

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 they have communicated an appointment date and time with the patient directly or intend to do so.

If consultant physicians are not able to accept the referral, they must communicate their reasons for declining the referral to the referring health-care provider.[18] Where a consultation is urgently needed, consultant physicians must provide suggestions to the referring health-care provider of alternative health-care provider(s) who may be able to accept the referral, and are advised to do so for non-urgent referrals as well.

Communicating with Patients

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.

Consultant physicians must communicate any instructions or information[19] to patients that they will 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 to the appointment date and time directly with them.

Preparing Consultation Reports

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

- Identifying information, including the name and contact information of the consulting physician, referring health-care provider, primary care provider (if different than the referring health-care provider), and patient;
- The date(s) of the consultation;
- The purpose of the referral as understood by the consultant physician;
- A summary of the information considered, including the patient's medical history and relevant family or social history, a review of systems, examinations and physical findings, tests or investigations undertaken, their purpose and their results, and any other pertinent patient data;
- A summary of conclusions reached, including any diagnostic conclusions or differential diagnoses;
- Treatments or interventions initiated or recommended and their rationale, including any medications prescribed or changes to ongoing medications;
- Outstanding investigations and additional referrals and their purpose;
- Advice given to the patient, including risks that were disclosed regarding initiated or recommended treatment and information regarding follow-up care needs; and
- Recommendations regarding follow-up by the referring health-care provider and whether ongoing care by the consultant physician is required.

When consultant physicians are involved in the provision of ongoing care, they must also prepare follow-up consultation reports when there are new findings or changes are made to the management plan. The purpose of follow-up reports is to ensure that those involved in the patient's care have the information they need to understand the patient's ongoing health status and needs, and to facilitate the coordination of care among those involved. Follow-up consultation reports must include a summary of:

- The original problem and any response to treatment;
- Any subsequent physical examinations related to the system(s) or problem(s) and their results;
- Any laboratory or investigation results, consultation reports, and any other pertinent data received since the previous visit related to the system(s) or problem(s); and
- Conclusions, recommendations, and follow-up plan(s).

Distributing Consultation Reports

Consultant physicians must distribute the consultation report and any subsequent follow-up reports in a timely manner, urgently if necessary, but no later than 30 days after an assessment or after a new finding or change in the patient's management plan. What is timely will depend on the nature of the patient's condition and any risk to the patient if there is a delay in sharing

the report, including exposure to any adverse clinical outcomes. If urgent, a verbal report may be appropriate, but must be followed by a written consultation report.

Consultant physicians must send consultation reports to the referring health-care provider and the patient's primary care provider, if different.[21] Consultant physicians must also take reasonable steps to identify other relevant health-care providers whose ongoing care of the patient would benefit from awareness of the consultation and share consultation reports with them as well.[22]

A copy of the consultation report must be retained in both the referring and consultant physician's medical record for the patient. Where the referring and consultant physician have access to a common medical record, the consultation report may be contained in that medical record.

Using Technology

Making a referral or preparing and distributing consultation reports may be facilitated by technological solutions that, for example, automatically produce required content or transcribe notes. Physicians are responsible to ensure the accuracy of their referral requests or consultation reports. If a referral or consultation report is produced and distributed automatically and prior to physician review, physicians must review it as soon as possible after it is sent to ensure it is accurate. If there are any errors, physicians must follow-up in a timely manner with those to whom the referral or consultation report has been sent.

[21] Under *PHIPA*, physicians can assume they have patient consent to share personal health information with those in the patient's circle of care unless the patient has expressly withdrawn their consent to do so.
[22] See Footnote 21.