

CPSO CONTINUITY OF CARE 2018

I am commenting on the Draft Policy on WALK-IN CLINICS (WIC).

DEFINITION (Lines 27-31)

I would recommend expanding the definition as follows:

- An office/clinic which provides episodic care, to orphan patients or patients of other family physicians
- An office/clinic which is available on a no appointment or walk-in basis, which makes up at least 20% of its practice by visit volume
- and advertises as “Walk-in” with at least an office front window or door sign
- whether open during evenings/weekends or not

MEETING THE STANDARD OF CARE (Lines 59-72)

The assessment by the WICs should be appropriate to the chief complaint indicated. Consequently, the billing for the assessment should be in an appropriate and ethical manner. Some groups of a rostered model of practice (such as FHO, FHT) have been negated by WICs billing general assessments for minor ailments.

FOLLOW-UP (Lines 73-82)

I would strongly agree with communication to other treating physicians, notably to the patient’s Primary Care Provider (PCP). In order to do so, clinic staff would have to inquire upon registration to obtain this information. WICs could have available in their offices a master list of community PCP names, addresses, phone numbers, faxes, email which would assist in communication. In the interest of continuity of care, a report or copy of the visit should be definitely be forwarded to the PCP within 24-48 hours.

Requisitions for testing should be c.c.’d for results to go to the PCP.

I disagree with the requirements for WICs to take full responsibility (Lines 80-82). It could be perfectly appropriate that follow-up be with the PCP. A recent BMJ Primary Care study showed that patients fare better seeing their PCP, who knows them best. For follow-up, especially in the case of minor ailments, patients should be given the option of doing their follow-up with their PCP.

In the case of a recommendation for specialist referral, especially if non-urgent, patients should be given the option of having this also being arranged by their PCP.

With the PCP primarily taking on the responsibility of their patients’ follow-ups and referrals, it makes the WIC the provider of mainly episodic and/or urgent care, thereby becoming part of the Primary Care

Team. In our financially strapped Health Care System, that is about time. As well, the role of the PCP continues, or is even enhanced, as primary coordinator of medical care, and custodian of information and the records. In cases of minor visits for patient convenience, the patient should definitely be referred back to the PCP. The PCP knows the patient's conditions, past and present, quite well and the patient might not even require a referral. All is this functions well as long as the visit information is promptly communicated from the WIC to the PCP.

Many WICs are corporate owned and have physicians working on a part-time basis. There are often a roster of various specialists who are available part-time from different fields. The WIC physician might be under corporate pressure to refer to the specialist coming later in the week. As an example, a patient with a cough due to an ordinary viral upper respiratory illness has been known to have a referral to a respirologist in the same clinic a few days later. Perhaps one could consider that a WIC should never refer a patient rostered to another PCP to a specialist except to an Emergency Department on an urgent basis!

WIC physicians should certainly be capable of making a clinical judgement of the urgency of further testing or referrals. A requirement for WIC to do (non-urgent) testing and referrals further contributes of the fractionation of care of the patient, which is not in their best interest.

BEING AVAILABLE (Lines 83-91)

Should a clinic calling itself a Walk-in Clinic, providing episodic semi-urgent or minor care, be required to be available for a minimal number of "after hours", that is, evenings and/or weekends?

PROVIDING COMPREHENSIVE CARE (Lines 102-124)

There are some WICs which also function as comprehensive care rostered practices. When a non-rostered walk-in patient has arrived, some of these clinics ask the patient to "sign a form" to register to be seen. However, it has been known to happen that a patient already rostered to a PCP has been asked to sign a rostering form. Unknown to the patient, a rostering to the practice has occurred. If this practice is to take place, it should be mandatory that the patient is given informed consent: that they are rostering and joining this practice, and that they would no longer be patients of their current PCP. Otherwise, it should be considered professional misconduct to roster a patient who is already rostered elsewhere to the practice without making the patient fully aware of the consequence.

Respectfully submitted