Feedback on the Continuity of Care draft policy from Peer Assessors of Walk-In clinic practices:

As physicians who provide walk-in care as well as conduct peer assessments for walk-in practices, we have reviewed the recent draft policy on continuity of care, with particular focus on the section for Walk-In Clinics. The following is feedback on a few issues raised by the policy.

In the Walk-In Clinics draft policy, under the section for 'Coordinating with Other Health-care Providers', line 92-101, it reads:

"Physicians practicing in a walk-in clinic must provide the patient's primary care provider, if there is one, with a record of the encounter."

As it is written, this mandates walk-in physicians to send a copy of every encounter note to family physicians (those with family physicians identified). This seems excessive and overly burdensome administratively for many minor problems that present to a walk-in clinic that does not impact continuity/chronic care (e.g. minor cold/URI, ankle sprain, minor laceration, etc.).

Arguably, this level of added paperwork and administration will cause more problems for the family physician who now will be even more overwhelmed with further paperwork that won't contribute to chronic patient care. The volume of patients seen on a daily basis in the walk-in/primary care setting would lead to a backlog of paperwork on both the walk-in clinic side and family doctor side which itself can overcrowd attention to more urgent reports and patient care issues, as well as take time away from direct patient care by physicians bogged down by paperwork, which ultimately works against continuity of care and accessibility.

Certainly, we agree where appropriate and helpful for the care of the patient to share clinical information, a copy of any tests, referrals or notes would be sent to the family doctor to facilitate continuity of care. It would be more practical and helpful for the policy to allow for clinical judgement to play a role in selecting appropriate encounters/clinical information to send to family doctors instead of sending notes for all encounters indiscriminately, however minor and non-contributory to chronic care.

This policy also seems at odds with emergency physicians who do not seem to be included (Executive Summary: Continuity of Care, line 55-56: "This policy also does not address the provision of episodic care in other practice environments or settings."). In many cases, the walk-in/urgent care clinics functions like a low acuity emergency department. Additionally,

Regarding the draft policy on ‘Availability and Coverage’, under section ‘Facilitating Access to Appointments’ (lines 58-65) it addresses the preference for patients to seek their regular family physician for care rather than walk-in clinics and emergency rooms. It specifies family physicians ‘must structure their practice in a manner that allows for appropriate triaging of patients with time-sensitive or urgent issues’. It is agreed that ideally, patients should seek care from their regular family physician. In our experience with many family physicians, they already provide timely access but patients continue to seek care from alternative sources (walk-in or emergency). The availability of access is not the only driver for patients going to walk-in clinics or the emergency department. Patients often work and live or
attend school in very different locations. For a patient, going to a walk-in clinic closer to where they are at the time for an acute issue is a practical choice for the patient. Availability of their family physician will not impact their care choice. From the walk-in perspective, many patients also go to a walk-in clinic to seek services that their family doctor may not provide (e.g. splinting, point-of-care imaging, suturing, etc.) or in many other cases, just wanted to go to different sources of care as a preference. Some patients also seek care from a walk-in clinic even when they have a scheduled appointment with their family doctor on the same or next day. It is not uncommon for patients to seek multiple assessments for the same problem. There is an element of patient accountability in healthcare usage that should be acknowledged. The language in this policy places an unfair burden on family physicians in managing where patients seek care on their own free-will. Perhaps an acknowledgement of the role of patient accountability/choice in this policy would improve the message it is trying to deliver.

In the same draft policy ‘Availability and Coverage’ under section ‘Coordinating Coverage for Temporary Absences’, it states: ‘physicians must arrange for another health-care provider(s) to provide patient care during temporary absences from practice’. The policy includes vacations, leaves of absence, unplanned absences (e.g. illness, family emergency). The intention of this policy is appreciated and alternative care coverage should be provided where resources are available. However, the use of the word ‘must’ poses a challenge for physicians who are unable to find another health care provider during their absence, despite all efforts to find one. In this climate of physician shortage and in more rural settings where there are already few physicians available, it is not unexpected that a physician is unable to find a locum to cover their absence. In such situations, it is not reasonable to expect a physician continue to work indefinitely without an option for time-off, parental leave, recovery from illness or grieving of family death. There needs to be a balance in this policy to recognize and respect the physical and mental health of the physician. The College describes “Acting in the best interest of the patient” as an element of professional values. However, it can not be at the expense of the physician’s personal well-being (physical and mental) which would not benefit patient care.

There is a real risk of driving physicians out of smaller communities or discouraging physicians to start a practice in more rural settings where locum coverage or a shared practice is difficult.

Some flexibility in this policy would set a more realistic tone. For example, changing the word ‘must’ to ‘should’ (“Physicians should arrange for another health-care provider(s) to provide patient care during temporary absences from practice.”), and/or removing illness or family emergency from the type of absences covered by this policy.
In summary, we appreciate the intent of the Continuity of Care draft Policies and indeed many elements described in the policy reflect practices that already take place in providing good patient care. There are three recommendations for amendment of the policy to better achieve the intent of this policy without stifling physician management of their practices that may work against continuity of care.

1. Allow professional judgement in deciding which walk-in visits would benefit from sharing of medical information with the family doctor instead of overwhelming family physicians with excessive medical notes that will crowd out attention for more pressing issues.
3. Allow more flexibility in how a physician arranges alternative care for their patients during absences, may perhaps include education of patients on where to seek medical attention when no formal locum coverage or shared care options are available. Removing of ‘illness’ and ‘family emergency’ from types of absences that require arrangements for another health-care provider(s) to provide patient care.

Sincerely