The College of Physicians and Surgeons of Ontario
80 College Street,
Toronto, ON M5G 2E2
Attention: Policy Department

RE: Continuity of Care Draft Policies

November 2, 2018

Dear Members of the CPSO Policy Committee,

On behalf of all of our Physician Partners, our Family Health Organization and our Executive Committee, I am providing feedback on the CPSO draft policies regarding Continuity of Care, including the suite of companion policies that set out expectations regarding Availability & Coverage, Managing Tests, Transitions in Care and Walk-in Clinics. Our physicians are well-positioned in our health care system to provide the CPSO with thoughtful feedback, from multiple perspectives, regarding the coordination of care for all patients. We are compelled to formally respond because these misdirected draft policies will put patients at risk.

The CPSO has identified “key themes” including the recognition that “patient interactions with the health-care system are best viewed not as discrete events, but rather as a set of interactions that require oversight and management”. We agree that the introduction of standard processes for scheduling appointments, reporting results, tracking patient encounters and communicating with patients has the potential to be highly impactful in patient health outcomes. However, the consequences of these CPSO draft policies will not improve patient-centered care because the recommended processes are ambiguous, inefficient, unsecure, impracticable, limited in scope, paternalistic and they contradict well-established protocols for urgent and non-urgent care.

Our Perspective:
The Peterborough Clinic has been operating as a multi-specialty partnership of physicians for almost 100 years. We currently represent 40 physicians; including 21 primary care physicians operating as a Family Health Organization and also working as hospitalists, a coroner, in emergency medicine, in remote northern areas, in long-term care facilities and a member of the LHIN. We also partner with the local Family Health Team and offer on-site clinician services for patients including: mental health, dietician, INR monitoring, COPD, smoking cessation, foot care and cognitive assessments. We represent 19 specialists practicing in Paediatrics, Obstetrics, Ophthalmology, Gastroenterology, General Surgery, Cardiology, and Dermatology. Our specialists share their time between our clinic and the regional hospital located directly across the road and several lead areas of hospital administration. Our specialists also contribute their services to weekly clinics at other hospitals outside of our region. We also work closely with our building tenants who offer services such as laboratory, radiology, audiology, pharmacy, orthotics, physiotherapy and recently, dentistry. Our combined experience certainly represents a meaningful cross-section of the day-to-day realities of delivering medical care in Ontario.

Our clinic was an early adopter of electronic medical records and has continued to maintain a robust EMR (Accuro) which operates as a single source of patient records (including referrals and results) among all of our physicians. Our EMR is connected with OLIS and HMR and PACs and our local health team clinicians. We actively research new methods of communicating referrals and results for patients using information systems with organizations such as OntMD and eHealth and we participate in pilot projects and studies such as BORN. Unfortunately, we consistently discover that the technical limitations of new applications prevent efficient and safe systems of information sharing. The poorly constructed architecture of the broad health information system in Ontario remains to be the most significant barrier to the coordination of care and effective communication with, and on behalf of, our patients.
After thorough consideration of the suite of draft Continuity of Care policies, we applaud the CPSO for addressing the challenges that many patients face in navigating our health care system. We also appreciate that the CPSO has acknowledged that a separate white paper is required to address the limitations of the health information system in Ontario and that the draft policies presented are intended to focus on improvements that are within the control or influence of physicians. We are extremely concerned, however, that the CPSO's attempt to hold physicians accountable for an improved manual system of communications in lieu of, or in advance of, creating an automated system is not a realistic objective. The province has attempted and failed to create this comprehensive data sharing system for two decades.

Below are our specific concerns about the entire suite of policies under the Continuity of Care umbrella:

**Availability & Coverage**
The requirements to triage patients for urgent care and respond to other physicians is a reasonable notion that is already achieved in today's system. The terminology used regarding "timely and professional manner" is ambiguous and does not accomplish change, if any is actually required.

The coverage arrangements for all physicians to ensure their patients have 24/7 access to care within the system are unrealistic and somewhat unnecessary. Arranging coverage can be very difficult outside of group practice. Locums are rarely available and usually require notice that is not available for unexpected sickness, family emergencies, or other absences. The policies also suggest that 24/7 coverage must be available at all times for critical test results during regular working days. These requirements do not address how labs process test results; tests drawn on stable patients during the day but batched for testing in the middle of the night. There is also an unclear delineation between urgent results addressed by primary care providers versus those to be addressed by hospital emergency rooms. The CPSO has created significant obligations for physicians in a vacuum without allowing for situations that even the most dedicated physicians cannot achieve. Solo physicians or specialists who operate alone in rural communities will find this to be an impossible standard. The CPSO has not addressed these issues within the draft policies and will contribute to physician burn-out and a correlated decline in patient care. The OMA has succinctly stated that "continuity of care is not synonymous with continuous 24/7 access...and that maintaining physician health and wellbeing is essential to the sustainability of our health system to provide excellent care for our patients." Without adequate resources for coverage and significant clarifications in the policy this is an unattainable standard.

Another issue for rural communities is that we have been unable to recruit some key specialists for many years and our patients must travel for that care. Specialists are unwilling to move to communities where they are solely responsible for all patients in the region. The CPSO policies on coverage will increase the demand for group practice and further discourage specialists from leaving large cities.

The primary care physicians in Ontario previously moved away from a model that requires in-patient hospital rounds and 24/7 coverage which was in place for many decades. The reason for that change was to support physicians in providing comprehensive, preventative patient care and to resolve schedules that were untenable. Furthermore, the complexity of care has increased over time. The CPSO proposal will return primary care physicians to the model that proved faulty in the past.

While we agree that physicians must provide clear communications for patients, the policy is ineffective and ambiguous as written. The policy does not provide for new methods of communication such as text or email and does not differentiate between urgent and non-urgent matters. We strongly disagree with the CPSO's recommendation for voicemail coverage. Voicemail provides a false sense of security to patients who call about acute symptoms despite warnings to the contrary. Voicemail does not allow a provider to assess the need for care at the time the care is required. Voicemail puts patient care at risk. Additionally, voicemail creates a forum for a high volume of unnecessary calls which diverts resources from in-office interactions and simply does not achieve better patient care. Lastly, the policy suggests answering voicemail within a "timely fashion" and this is an unclear requirement which will not serve to help patients understand their access to care. Today, we already have appropriate avenues for after-hours calls for urgent care and non-urgent care should be treated consistently for all patients during office hours.
Patient engagement as it relates to coverage is ideal but the requirement to encourage patients to develop a list of their health status items to provide to providers when their physicians are unavailable cannot form a standard that physicians are judged by. Many patients do not take action to support their own health. The failed, province-wide information system would largely solve this requirement. In lieu of that system, physicians cannot be held accountable for a manual substitute.

Managing Tests
Physicians in our clinic are closely monitoring test results and we have a robust EMR system to assist in the appropriate documentation. As previously stated, the province-wide technology for test results outside of our EMR is severely lacking. The policy for tracking these results is ambiguous in its description of “high-risk patients” and due to constantly changing scenarios, it would be unrealistic to prescribe each situation which would be a candidate for intense tracking. The CPSO has failed to adequately allow for patients who do not complete the tests in spite of encouragement from their physicians. The CPSO has also failed to address situations where laboratories do not highlight the significance of a critical test result or complete the testing in a timely manner. The accountability for tracking critical tests cannot rest on the physician alone. Increased medico-legal liabilities will result from these requirements without adequate language for contingencies.

We completely agree with the policy on ordering tests; clear documentation of contextual patient information and providing a copy to the patient’s primary care provider are essential. The CPSO should address patient privacy in the amount of documentation provided on the requisition because this is lacking in the policy document.

In terms of communicating test results, we agree with and we currently ensure that patients have access to this information and the ability to ask follow-up questions. For critical, after-hours, test results the lab should be contacting the physician who is on-call for the ordering physician. All physicians should have arrangements in place to accept after-hours calls but should not be personally required to be available at all times. Our family health organization has a designated physician on-call every night. The CPSO must also address labs that do not process test results until the middle of the night because they are batched when the result could have been made available during the day. Professional judgement is in place for physicians to work with labs and patients today. However, by creating these ambiguous and unrealistic policies, it will hamper the process.

Likewise, with test results received in error, the CPSO has suggested that the physician is solely responsible for ensuring that the proper physician, the lab and the patient are notified of the error and that even incidental notification of clinically significant results must be communicated to these parties. While we agree that physicians must assist in this communication effort, it is not appropriate to place the responsibility solely on physicians who are completely unknown to the patient and the ordering physician. Often the test results do not have adequate information for unattached patients or physicians who are unknown to the physician receiving the results in error. The CPSO policy will result in physicians investing time in inefficient communications, researching patient information and diverting resources for their own patients to unnecessary activity. The lab is responsible for the error and unclear contact information and the lab should also be responsible for correcting it. We propose that physicians should contact the lab with a notice of “return to sender” in the event the lab contact information is clear.

Transitions in Care
We applaud the CPSO’s attempt to standardize the communication between referring physicians and specialists although the CPSO policy is unclear on the appropriate timing for tracking referrals. We have the capability in our EMR to track referrals and we use our professional judgement to ensure critical referrals are achieved. However, the requirement for referring physician to contact patients with specialist appointment times adds an unnecessary layer of communication that neither helps patients, nor saves time. Improved communication will only be achieved if the consulting physician directly communicates with the patient to resolve questions, logistics, scheduling conflicts and obtain updated contact information in a timely manner. Furthermore, this policy diminishes patient empowerment; patients ultimately need to be responsible for attending appointments to support an efficient system.

The CPSO has overlooked the common situation where a referring physician has no local specialist in a rural community. Our physicians are making referrals to out-of-town specialists where it is very difficult to determine if they have availability, accessibility, and sub-specialties in scope. Referring physicians are not able to ensure ideal medical care is available to their patients within the ambiguous and wide-reaching terms that the CPSO has referenced.
Referring physicians are often working in hospital in-patient and emergency care and are seeing patients that are not enrolled with them. Once the physician changes shifts, the patient and the specialist cannot easily contact the referring physician. The CPSO policy on referrals is silent on this situation. This limitation will diminish any value the CPSO hoped to achieve for patients who are navigating the healthcare system.

Consulting physicians typically have practices that are in high demand. The 14 day response time may be accommodated with an automatic response mechanism to notify the referring physician of receipt, estimated appointment wait times or out of office notices. An automated response system, if possible, would help to prevent “blind referrals”. The CPSO policy was not clear on what “acknowledge a referral request” means. In practice, it is not realistic to expect that all referrals will result in a certain appointment date within two weeks. The CPSO should clarify the policy or significantly extend the response time. Likewise, the requirement to distribute consultation reports within 30 days is not achievable and in many cases not necessary for non-urgent or chronic patient care. Our specialists work with referring physicians to ensure that patient needs are met on a timely basis but prescribing these strict artificial timelines will not improve patient care and will serve only to distract specialists and referring physicians alike. These policies attempt a “one-size fits all” solution to complex scenarios.

The policy attempts to set parameters for referrals and discharge summaries that are impracticable and contradict established protocols in collaborative care environments such as hospitals where placing the responsibility for communication solely on the MRP will artificially limit the scope of the information available from a variety of disciplines involved with an individual patient’s care. In addition, the MRP is not necessarily the person dictating the discharge summary. For example, it may be an NPEC. Communications must be made clearer to be effective. The CPSO has developed these policies without addressing hospital administration changes required such as making the contact information available for consultation to primary care physicians after discharge and improving the quality of discharge notes for efficient follow-up with the patient. Hospitals need to be more proactive in ensuring timely discharge summaries. These policies are unrealistic without comprehensive changes in hospitals.

Walk-in Clinics

While we do not operate a walk-in clinic for unattached patients, we must state that these policies are unsustainable for walk-in clinics and virtual care clinics in our community and will cause them to close. We believe that walk-in clinics undermine the value of true comprehensive patient care but we acknowledge that they serve a very important need in the community and these policies put a large number of patients at risk of losing access to this care. The requirement for a walk-in clinic to become a patient’s primary care provider after a few visits is not realistic. Physicians in walk-in clinics do not allow for long appointment times necessary for full scope primary care. The policy as it is written is also ambiguous and will create more confusion in the system for patients who seek walk-in clinic care infrequently.

Notification of patient appointments at a walk-in clinic to the primary care provider contradicts patient rights to privacy, autonomy and self-determination. The CPSO policy is based on implied consent for every patient and this is unacceptable.

Conclusion

Beyond our specific concerns noted above, we have tangible examples of physicians (primary and specialists alike) who are strongly considering changing their roles in medicine in reaction to complex and unmanageable demands on their offices. Unlike many respondents, we are a large clinic with considerable resources, this discussion is not about the unfair provincial funding. We are concerned that many of our physicians who are past or nearing retirement age will be unmotivated to prolong their careers. We are also concerned about recruiting the new graduates who are considering other jurisdictions or other areas of medicine that they perceive to be less difficult to navigate. Our region has a high number of unattached patients and many are at risk of losing their physician to retirement without a viable replacement. A decrease in the number of physicians at this time would be catastrophic to our community. Consideration of this very real risk is enough to pause and reconsider the CPSO policies in context of the bigger picture of patient care for orphaned patients.
THE PETERBOROUGH CLINIC

These draft policies highlight some benchmarks that we can use to improve our clinic processes and communication among the multi-disciplinary specialists in our community. The vast majority of physicians and other clinicians that we work with across all areas of medicine are incredibly dedicated individuals focused on maintaining a high standard of care for all patients. Excessively onerous global policies applied to issues that may be isolated to a few members of the profession will drive diligent physicians out of their practices which will negatively impact patient care. The demographics of our rural population is weighted towards the elderly and vulnerable; making continuity of care an important initiative. However, the proposed policies are not driving the desired patient outcomes.

We request that the CPSO does not continue or at a minimum, completely revisits these draft policies in light of our concerns and valid comments from all areas of the profession.